HIV/TB AND THE LAW

A LEGAL RESOURCE

Reducing Human Rights-related Barriers to HIV & TB Services for Key and Vulnerable Populations

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A Legal Resource

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AIDS Foundation of South Africa under the Global Fund to Fight AIDS, Tuberculosis and Malaria-funded *Breaking Down Barriers: Programs to Reduce Human Rights-Related Barriers to HIV, TB & Malaria Services*

INTRODUCTION

In November 2018, the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) published a baseline assessment for South Africa titled *'Scaling up Programs to Reduce Human Rights Related Barriers to HIV and TB Services.'*

The finding of the assessment pointed to the following challenges in the response to Human Immunodeficiency Virus (HIV), tuberculosis (TB) and human rights in South Africa:

- poor implementation of protective laws and policies;
- limited sensitisation of police, particularly in relation to the rights of vulnerable populations, in particular, women, youth, sex workers, people who use drugs, inmates, lesbian, gay, bisexual, transgender and intersex (LGBTI) persons, and persons with disabilities.
- weak accountability mechanisms and limited awareness of how to access justice and legal redress for human rights violations, including limited work with the judiciary; and
- small scale human rights and gender-related programmatic responses with poor co-ordination between existing programmes.

To address human rights-related barriers to HIV and TB services in South Africa, the Global Fund baseline assessment identified the following strategies to be developed and implemented:

- Stigma and discrimination reduction
- Training for health care workers on human rights and medical ethics
- Sensitisation of law-makers and law enforcement agents
- Legal literacy
- HIV related legal services
- Monitoring laws, regulations and policies
- Reducing discrimination against adolescent girls and young women in the context of HIV

In responding to the Global Fund baseline assessment, the National Department of Health, South African National Aids Council, Stop TB Partnership and United Nations Development Programme launched a three-year Human Rights Plan in June 2019. The Human Rights Plan is also a direct response to Goal 5 of the South Africa's National Strategic Plan for HIV, TB and STIs 2017- 2022. This Plan seeks to address human rights and gender related barriers that increase risk and prevent people from accessing services, in particular, women, youth, sex workers, people who use drugs, inmates, LGBTI persons and persons with disabilities through:

- Reducing stigma and discrimination amongst people living with HIV or those with TB;
- Facilitating access to justice and redress for people living with, and vulnerable to HIV and TB; and
- Promoting an environment that enables and protects human and legal rights and prevents stigma and discrimination.

The Global Fund HIV & TB Programme includes a Human Rights Programme that seeks to reduce human rights and gender-related barriers faced by key and vulnerable populations to ensure that they can access and obtain services and improve their health outcomes. The Human Rights Programme includes work by the AIDS Foundation of South Africa (AFSA) and its various sub-recipients, one of which is ProBono.Org.

ProBono.Org is tasked to implement part of the Human Rights Plan with the goal of reaching key and vulnerable populations with a programme of customised and targeted interventions suggested in the Global Fund baseline assessment. The objectives of the programme is to promote an environment that enables and protects rights and prevents stigma and discrimination by providing legal empowerment and legal support to HIV and TB vulnerable and key populations.

The programmme activities include

- Legal empowerment targeting vulnerable and key populations
- Training of paralegals on issues related to HIV, TB and human rights
- Legal and paralegal support to community members whose human rights have been violated including pursuing identified matters to court
- Sensitisation of judiciary, law makers and traditional leadership especially those involved in traditional courts.

The production of the *'Reducing Human Rights Related Barriers to HIV & TB Services for Key and Vulnerable Populations: Legal Support Resource'* is part of the implementation of the aforementioned activities. Issues related to HIV and TB cut across different areas of law, and this poses a unique challenge in navigating through the relevant legislation and regulations that protect and promote rights and govern the actions of government in relation to these diseases and their impact on citizens and residents of South Africa. Accordingly, this Legal Resource gives practical information on current and evolving legislation, common law and policies pertaining to HIV and TB in South Africa with the aim of educating, sensitising and providing updated information to paralegal and legal practitioners who are engaged in offering legal advice and services to individuals and communities who are members of the vulnerable and key populations that are the focus of this programme.

Who is this Legal Resource for?

The Legal Support Resource is a legal tool on HIV, TB, human rights and law for paralegal and legal practitioners. The Legal Resource can also be used as a reference and guidance to people who work in the field of health and human rights.

How to Use the Legal Resource

Contents

Check the chapter content to find the chapter you need.

Numbering

Main sections in chapter are numbered: 1, 2, 3 etc. Subsections are 1.1 and 1.1.1 etc.

Referencing

All chapters have footnotes for references.

The Legal Support Resource can be read with the book titled *'HIV and The Law in South Africa: A Practitioners Guide' edited by Amelia Vukeya Motsepe. A publication by Lexis Nexis South Africa 2016* for more information.

Chapter Resource Material

- Legislation
- Regulations
- Policy documents
- Cases
- Reports, manuals, and other useful materials
- Websites

Acknowledgements

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The development process included the research by Mbalenhle Sikhosana (LLB), Nontsikelelo Hlokoza (LLB) and Paula Sindiso Zikhali (LLB). The legal resource was extensively edited and peer reviewed by experts in the various fields of human rights, namely, Tshegofatso Claudette Phala (BA, LLB), Prof Moses Retselisitsoe Phooko (BA, PGDip Human Rights, LLM, LLD) and Matilda Lasseko (BA, LLM, LLM). Bowman Inc employment law department, Lusanda Raphulu (BA Soc Science, LLB) and Bulela Mungeka (LLB) played a role in reviewing the employment law chapter.

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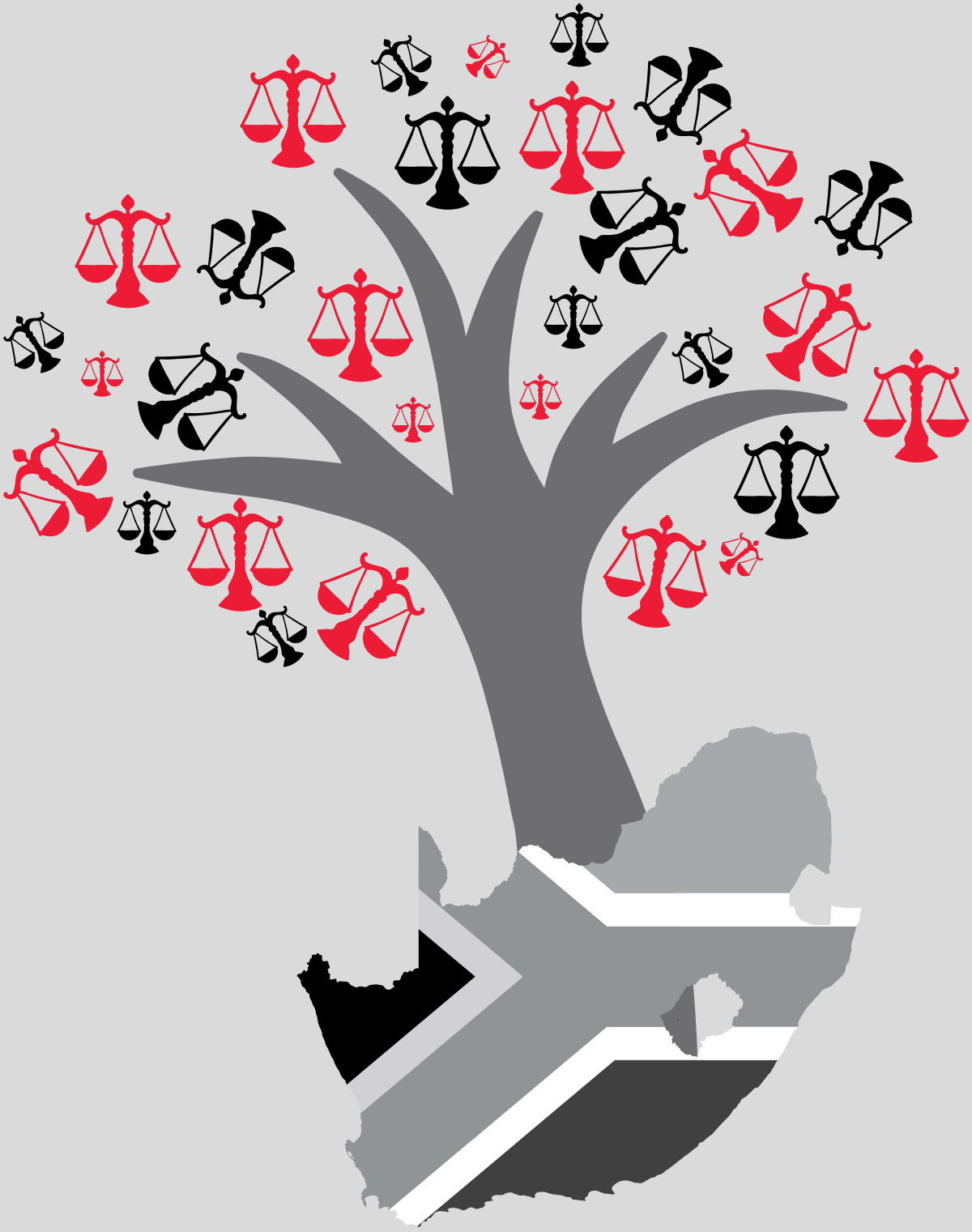

CHAPTER 1

INTRODUCTION TO THE SOUTH AFRICAN LEGAL SYSTEM

1. Introduction

The purpose of this chapter is to discuss the nature of South Africa's legal system to give context to available remedies on human rights violation related to rights of people living with the Human Immunodeficiency Virus and People with Tuberculosis. In particular, rights to access healthcare for key and vulnerable population that referred to in the subsequent chapters.

2. What is Law?

Law is a system of rules laid down by a body with the power and authority to make the law. It consists of enforceable legal rules governing relationships among individuals, and the state, and between individuals and their society. These set of rules are enforced by the state and failure to obey the laws result in certain consequences.

Law forms a legal system that protects the rights and responsibilities of both individuals and groups, and ensures social and economic interactions are conducted smoothly and peacefully.

2.1. What is the Law for?

In general the law is used to:

- Preserve public order and safety by protecting everyone from complete social disorder and anarchy.
- Protect individual rights and liberties by ensuring that everybody is equal before the law. This means that everyone is controlled by the law to ensure that all individual rights are protected equally, and that nobody is above the law.
- Organises day to day affairs of the country by setting out rules and boundaries of politics that preserves the political structure and process under which governance is possible. For example, the relationship between law and state is a written constitution.
- Regulates economic activity by facilitating and encouraging national, regional, and international trade in goods and services.
- Regulates human relationships by legitimising and controlling various aspects of interpersonal relations such as entering into marriages, distribution of family wealth, regulation of the parent-child relationship.
- Regulate international relations by a branch of law called public international law. This involves the creation of states, definition of state boundaries, diplomacy, and humanitarian law.
- Preserve legal order, and in cases where the law and morals overlap, some morals are given the force of law.

2.2. The Distinction Between Legal and Social Rules

- Law as we practice it, is a system of rules which guides and directs our activities in most of our day to day life. For example, the purchases we make in a shop, our conduct at work, and our relationship with the state are all built upon the foundation of legal rules.
- Social rules are not laws in the formal sense, but merely social conventions or perceptions of 'proper' behaviour or morals.

2.3. Where does the Law come from?

The law is found in:

- Statutes made by Parliament. These are also referred to as *'Acts of Parliament'*.
- Common law decided in courts also referred to as *'Case Law'*. These are decisions made in court after interpreting the law.
- Customary law is written and unwritten rules which have developed from the customs and traditions of communities.

A detailed discussion on customary law is in Chapter 9.

2.4. Different Kinds of Law

- **Constitutional law** is the body of law which defines the relationship of different authority within a state, namely, the executive, the legislature and the judiciary including rights of citizens.
- **Civil law** deals with the disputes between individuals, organizations, or between the two, in which compensation is awarded.
- **Criminal law** is the body of law that deals with crime and the legal punishment of criminal offenses.

3. Constitutional Democracy and Government

3.1. Definition of Constitutional Democracy

South Africa is a constitutional democracy. Democracy comes from the Greek word *demokratia* which means *'government by the people'*.[1] The State is given the power to govern by the people, but this power is limited to ensure that the State does not abuse it. The power must be exercised within the confines of the Constitution of the Republic of South Africa, 1996. The Constitution is the Supreme (highest) law of South Africa. State power is limited by restricting the range of things that the Organ of State can do and by prescribing the procedures, the Organ of State must follow in doing those things.[2]

In simple terms, democracy is:

- Balancing rights and responsibilities of the State and its Citizens. This means that in as much as citizens expect the government to do things, for example, providing healthcare services, education, housing, citizens also have the responsibility to obey the law.
- Balancing the rights of the majority with protection of minorities.
- Achieving a greater balance in society so that there is greater equality for all over a period of time.

3.2. The Structure of Government and Function of Government

The Constitution divides government into three branches of authority:

- The Executive;
- The Legislature; and
- The Judiciary

The division of authority is also in three spheres, namely, national, provincial and local. The Constitution sets out the composition, functions and authority of the three branches of government at all three spheres. The national government authority is allocated in the following way:

- The **Executive** which develops policy and implements the law;
- The **Legislature** makes law and holds the executive to account; and
- The **Judiciary** interprets the law in accordance with the Constitution, to ensure compliance with it, and checks that the legislature and executive carry out their constitutional duties.

3.2.1. The Executive Authority

3.2.1.1. National and Provincial Executive

The executive consists of the **President**, the **Deputy President**, the **Cabinet Ministers** at National level and the Premier and Members of the Executive Councils (MEC's). The President is the head of the State entrusted with maintaining the supremacy of the Constitution and is required to promote the unity and interest of the nation.[3] The President exercises national executive authority together with other members of the Cabinet, including the Deputy President and other ministers appointed by the President.

The Executive is empowered to:

- implement legislation;
- develop and implement policy;
- direct and co-ordinate the function of government departments;
- prepare and initiate legislation; and
- perform other function as directed by the Constitution and legislation.

Section 84 of the Constitution tasks the President with the following responsibilities:

- assenting to (agreeing to) and signing Bills passed by Parliament;
- referring any Bill back to the National Assembly (NA) if the President thinks that all or part of it is unconstitutional;
- referring a Bill to the Constitutional Court for a decision on its constitutionality if the President has concerns about it; and
- appointing Commissions of Enquiry.

1. Dictionary.com accessed from https://www.dictionary.com/e/politics/democracy/ on 28 March 2020.
2. Ian Currie & Johan De Waal (eds) "The Bill of Rights Handbook" (Juta 2013) at page 8.
3. Section 1 of the Constitution of the Republic of South Africa.

Cabinet Ministers are appointed by the President from the National Assembly.[4] The President assigns powers and functions to Cabinet Ministers, who are accountable to Parliament – individually and collectively – for the exercise of their powers and the performance of their functions. All members of Cabinet must act according to the principles and framework of the Executive Members Ethics Act.[5]

The Executive in each Province is called the Executive Council which is headed by the Premier. The MEC's are accountable to their Legislatures in the same way as the Cabinet is accountable to Parliament.

3.2.2. The Legislative Authority

The term "legislature" means a body of elected representatives that makes laws. The function of the legislature is to formulate, debate and pass legislation. It also provides a forum for public participation, in which the public can contribute to issues that affect them.

The national legislature is referred to as Parliament, and is vested with legislative authority for the country at national level. All nine provincial legislatures each have legislative authority at Provincial level. This legislative authority consists of the NA and the National Council of Provinces (NCOP). The NA and the NCOP have powers to oversee the conduct of the executive. The powers of the NA and the NCOP are vested in Section 56 and 69 of the Constitution respectively.[6]

The Legislative Authority of Parliament is also vested with the authority to amend the Constitution, including power to amend the provisions of the Bill of Rights. In addition, it also has the power to pass legislation on all matters, except for a small category of functional areas listed in Schedule 5 of the Constitution.[7] However, the Constitution also allows Parliament to pass legislation on Schedule 5 issues if it is to 'maintain essential national standards ... or economic unity', or to 'establish minimum standards required for the rendering of services.' [8]

3.2.2.1. Provincial Legislatures

Each province has a legislature in which members are elected from provincial lists on the basis of the number of votes received by a political party. A provincial legislature is responsible for passing laws for its province as defined by the Constitution. These laws are only effective for that province. Provincial legislatures are bound by the Constitution and their own provincial constitutions, where these exist. Provinces do not have any general power to legislate. Instead, they may pass laws only on 'functional areas' that are expressly identified in Schedules 4 and 5 of the Constitution.

The functional areas of concurrent national and provincial legislative competence set out in Schedule 4 include:[9]

- health services;
- education except tertiary education;
- housing;
- social welfare services; and
- issues that are "reasonably necessary for, or incidental to, the effective exercise of a power concerning any matter listed in Schedule 4.[10]

The Provincial Executive implements and administers national legislation in two ways:

- section 125(2)(b) of the Constitution provides for provinces to implement national legislation within the functional areas listed in Schedules 4 and 5, unless the Constitution or the relevant national legislation expressly says otherwise; and

4. Ibid.
5. No 82 of 1998.
6. See Parliamentary Monitoring Group ' The Structure of Government 'accessed from https://pmg.org.za/page/structure-of-government on 14 October 2020.
7. A Hassim, M Heywood and J Berger (eds) *Health and Democracy: A Guide to Human Rights, Health Law and Policy in Post-Apartheid South Africa* (Cape Town: Siber Ink, 2007) at pp. 26–29 at pg 62.
8. Section 44(2).
9. Op cit note 6.
10. The role of the Provincial legislature was described by the Constitutional Court in the recent case of *Matatiele Municipality v President of the Republic of South Africa (2) (the Matatiele Municipality* case, CCT 73/05, 18 August 2006) at para 47 *"The role of a provincial legislature goes beyond legislating for the province; it includes taking part in the national legislative process. ... The Constitution contemplates the provincial legislatures, consistent with our constitutional scheme, will be involved in the law-making process at national level, such as when they are required to confer voting mandates on their NCOP delegations or when they consider whether or not to approve proposed constitutional amendments that alter their boundaries."*

- section 125(2)(c) of the Constitution provides for provinces to administer national legislation dealing with other issues if the relevant national legislation expressly delegates this function to the province.

3.2.3. The Legislative Authority

Municipalities have a range of objectives, such as providing services to communities in a sustainable way and promoting a safe and healthy environment. Section 155 of the Constitution deals with the three types of municipalities that collectively make up local government:

- Category A – metropolitan councils;
- Category B – local councils; and
- Category C – district councils.

The Local Government: Municipal Structures Act[11] sets out more detail on establishing local government structures. With regard to legislative authority a *"municipality may make ... by-laws for the effective administration of the matters which it has the right to administer."*[12] This means that municipal councils can pass by-laws which are referred to as local government legislation on a range of health-related issues such as water and sanitation services, refuse removal and municipal health services.

The executive authority of a municipality rests with its municipal council. The Municipal Structures Act allows for a range of different executive structures, such as executive committees and executive mayors. A municipality has executive authority on a limited list of local government issues which are set out in Part B of both Schedules 4 and 5 of the Constitution, as well as on other issues delegated to municipalities by national or provincial legislation.

3.2.4. The Judicial Authority

The judicial authority of the country rests with the courts which are independent and subject only to the Constitution and the law. The function of the courts is to interpret the law in accordance with the Constitution and to ensure compliance with the law. The courts also has the responsibility to check that the other two branches of government comply with their constitutional mandate.

Not all courts have full constitutional jurisdiction to hear constitutional matters. However, section 39 of the Constitution requires all courts, tribunals and forums to 'promote the spirit, purport and objects of the Bill of Rights' when 'interpreting any legislation, and when developing the common law or customary law'. Further, section 170 states that only the Constitutional Court, the Supreme Court of Appeal (SCA) and the High Courts (and courts of a similar status) may 'enquire into or rule on the constitutionality of any legislation or any conduct of the President'.

In constitutional cases, courts have wide powers to grant what section 38 of the Constitution refers to as 'appropriate relief'. According to section 172 of the Constitution, a court with jurisdiction must 'declare that any law or conduct that is inconsistent with the Constitution is invalid to the extent of its inconsistency' and may 'make any order that is just and equitable'. Without this power, courts would not be able to ensure that rights have real meaning. In *Fose v Minister of Safety and Security*[13] the legal issue before the court was whether 'constitutional damages' could and ought to be awarded as appropriate relief in terms of the interim Constitution for the alleged breach of constitutional rights. It was argued that the state should be required to pay 'constitutional damages' over and above common law damages in order to vindicate the constitutional rights of the appellant, where officials, who are organs of state, have infringed fundamental rights the court noted that 'Appropriate relief will in essence be relief that is required to protect and enforce the Constitution'[14] and therefore necessary to protect and enforce the Constitution.

11. 117 of 1998.
12. Section 156(2) of the Constitution.
13. 1997 (3) SA 786 19.
14. Ibid at para 19.

4. The Courts[15]

4.1. The Constitutional Court

The Constitutional Court is the highest court on constitutional issues which means that it only considers "constitutional matters, and issues connected with decisions on constitutional matters".[16] The Constitutional Court has jurisdiction to make the final decision on "whether a matter is a constitutional matter or whether an issue is connected with a decision on a constitutional matter".[17]

The Constitutional Court is not the only court that has the jurisdiction to deal with constitutional cases. However, it does make the final decision about whether an Act of Parliament, a provincial statute or the conduct of the President is constitutional. Even if the SCA or a High Court declares that a statute is unconstitutional, the declaration must be confirmed by the Constitutional Court to become effective. These kind of cases are automatically referred to the Constitutional Court for what is known as confirmation proceedings.

While, the Constitutional Court can decide to hear any case directly, most cases come to the Constitutional Court on appeal from other courts, usually a High Court or the SCA. But some cases come to it directly and automatically, as it has exclusive *jurisdiction* to deal with a range of issues, such as:

- certain disputes between organs of state;
- the constitutionality of amendments to the Constitution; and
- the certification of provincial constitutions.

With regards to Constitutional remedies, the courts have developed the following remedies to give full and proper effect to constitutional rights:[18]

- mandating the state to do something that it previously refused to do;
- reading words into an existing statute to make it constitutional;
- removing unconstitutional words or entire sections from legislation;
- ordering the state to file documents in court explaining how it aims to give effect to a particular court order; and
- ordering the state to pay *"constitutional damages"*.

4.2. The Supreme Court of Appeal

The SCA is the highest court of appeal except in constitutional matters. It only hear appeals, issues connected with appeals and other matters that may be referred to it in circumstances defined by an Act of Parliament. The SCA, does not have *original jurisdiction* – it has the authority to hear matters that no other court has had an opportunity to hear.

4.3. High Courts

The High Court has jurisdiction to deal with any case, unless a statute specifically allocates the case to another court or forum, namely a Commission or a Tribunal.[19] High Courts also have broad constitutional jurisdiction, but this does not extend to cases falling within the exclusive jurisdiction of the Constitutional Court and those that are expressly delegated by an Act of Parliament to another court of a status similar to a High Court.

4.4. Magistrate's Court

The Magistrate court is the usual entry point for the majority of people who go to court. The Magistrate court consists of the Regional courts and district court. Magistrate's courts and other courts may decide on any matter determined by an Act of Parliament but may not enquire into or decide about the constitutionality of any legislation or any conduct of the President.

15. See Department of Justice and Constitutional Development 'Courts in South Africa' accessed at https://www.justice.gov.za/about/sa-courts.html on 11 October 2020.
16. Section 167(3)(b) of the Constitution.
17. Section 167(3)(c) of the Constitution.
18. See Head of Department: *Mpumalanga Department of Education and Another v Hoerskool Ermelo and Another* (Federation of Governing Bodies for South African Schools (FEDSAS) as Amicus Curiae) 2010 (2) SA 415 (CC); *National Coalition for Gay and Lesbian Equality and Another v Minister of Justice and Others* 1999 (1) SA 6.
19. For example, the Competition Act, 89 of 1998 sets up the Competition Commission, Competition Tribunal and Competition Appeal Court to deal with competition law cases and Labour Relations Act, 1995, for example, is currently reserved for the Labour Court to deal with the interpretation of the right to fair labour practices in terms of the Act.

4.5. Specialised Courts

- **Small claims court** deals with minor cases involving sums of R20 000.00 or less;
- **Electoral court** deals with electoral issues;
- **Labour court** deals with issues pertaining to labour relations;
- **Land claims court** deals with matters of land distribution;
- **Equality court** is designated to hear matters relating to unfair discrimination, hate speech and harassment; and
- **Family court/Advocate** deals with matters related to family law such as the custody of children, divorce and adoption.

5. State Institutions which Support Constitutional Democracy

To give substance to constitutional rights, the Constitution established a range of structures designed to promote and strengthen constitutional democracy. There are four Chapter 9 institutions that are relevant to public powers:

5.1. The Public Protector

Section 182 of the Constitution empowers the Office of the Public Protector to deal with 'any conduct in state affairs or in the public administration in any sphere of government that is alleged or suspected to be improper or to result in any impropriety or prejudice'. The Public Protector has the authority to investigate and report on this kind of conduct, and then 'to take appropriate remedial action.'

5.2. The South African Human Rights Commission

Section 184 of the Constitution requires the South African Human Rights Commission (SAHRC) with promoting respect for human rights, a culture of human rights, and protecting, developing and achieving human rights.

In particular, the Constitution mandates the SAHRC to monitor and assess the observance of human rights. This is to be achieved in various ways, such as by investigating and reporting on the State's compliance with the Constitution and by taking steps to address violations of human rights that occur.

A further example of the way in which the SAHRC attempts to discharge its mandate is by requiring various government structures to provide it with information on the steps that the State has taken to carry out its constitutional obligations on specific socio-economic rights.

The SAHRC's annual report on socio-economic rights is largely based on this self-reporting, without any mechanism for assessing the accuracy of the information provided which is a disadvantage. A key factor in adopting this methodology is the limited capacity and financial resources of the SAHRC.

5.3. The Commission for Gender Equality

Section 187 of the Constitution sets out the mandate of the Commission for Gender Equality (CGE) to promote respect for gender equality and protect, develop and achieve gender equality. To enable it to do its job, the CGE's powers include 'the power to monitor, investigate, research, educate, advise and report on issues concerning gender equality'. The CGE is similar to the SAHRC, except that it focuses on gender rather than human rights in general. The CGE also monitors the State's adherence to International Agreements such as the Convention for the Elimination of All Forms of Discrimination Against Women.

5.4. The Auditor-General

Section 188 of the Constitution gives the Auditor-General (AG) the main responsibility for auditing and reporting on *'the accounts, financial statements and financial management'* of the state, including national and provincial departments and municipalities. The AG also has jurisdiction to audit and report on 'any institution funded from the National Revenue Fund or a Provincial Revenue Fund or by a municipality'; and 'any institution that is authorised in terms of any law to receive money for a public purpose'. The AG, thus, has the power to monitor the financial affairs of anybody that is funded by public money, whether an official part of government or not. This means that the AG has an important role to play in ensuring that publicly funded healthcare services are not misused.

6. Other Structures which Support Constitutional Democracy

6.1. Public Service Commission

Section 195 of the Constitution sets out the basic values and principles governing public administration. These include accountability, fostering transparency 'by providing the public with timely, accessible and accurate information', and providing public services 'impartially, fairly, equitably and without bias'. Section 196 of the Constitution sets up the Public Service Commission as an independent body to:

- promote 'the values and principles set out in section 195, throughout the public service';
- ensure that officials perform their tasks in accordance with the Constitution; and
- investigate, monitor and evaluate 'the organisation and administration, and the personnel practices of the public service'.

6.2. The Independent Police Investigative Directorate

The Independent Police Investigate Directorate (IPID) was established by the Independent Police Investigative Act[20] enacted to give effect to section 206(6) of the Constitution, with a mandate to investigates all cases where the police have acted wrongly or have violated rights. In any democracy it is the police department which is given the greatest powers to infringe the rights of citizens. The IPID, as an independent body, is responsible for ensuring that cases in which misconduct on the part of police officers is alleged, are investigated impartially.

The IPID, considers complaints relating to deaths of persons in police custody or deaths which are as a result of police action; the involvement of police officers in criminal activities such as robbery, theft of motor vehicles and assault; and behaviour which is prohibited such as neglect of duties or breaking the South African Police Service (SAPS) code of conduct. It aims to help build public confidence in the police service.

6.3. The Judicial Service Commission

In terms of section 178 (5) the Constitution, the Judicial Service Commission advises government on any matter relating to the administration of justice and the judiciary, such as complaints about judges and the appointment of judges.

6.4. The Commission for Conciliation, Mediation and Arbitration

The Commission for Conciliation, Mediation and Arbitration (CCMA) established in terms of the Labour Relations Act, 66 of 199. It is an independent statutory body that helps anyone whose labour rights have been violated and/or is a victim of unfair labour practice involving such matters as dismissal, wages and working conditions, workplace changes or discrimination. It resolves disputes between employers and employees through conciliation, mediation and arbitration.

7. Application of the Bill of Rights in Law

The Bill of Rights is a cornerstone of democracy in South Africa. It enshrines the rights of all people in South Africa and affirms the democratic values of human dignity, equality and freedom. The State must respect, protect, promote and fulfil the rights in the Bill of Rights.

Section 8 of the Constitution states that:

(1) The Bill of Rights applies to all law, and binds the legislature, the executive, the judiciary and all organs of state.

(2) A provision of the Bill of Rights binds a natural or a juristic person if, and to the extent that, it is applicable, taking into account the nature of the right and the nature of any duty imposed by the right.

(3) When applying a provision of the Bill of Rights to a natural or juristic person in terms of subsection (2), a court—

(a) in order to give effect to a right in the Bill, must apply, or if necessary develop, the common law to the extent that legislation does not give effect to that right; and

(b) may develop rules of the common law to limit the right, provided that the limitation is in accordance with section 36(1).

20. Act 1 of 2011

(4) A juristic person is entitled to the rights in the Bill of Rights to the extent required by the nature of the rights and the nature of that juristic person.

Vertical application: The Bill of Rights applies to all matters between Citizens and the Government. It protects Citizens from having their rights infringed by the government.

Horizontal application: The Bill of Rights applies to matters between ordinary people, which then protects Citizens from having their rights infringed by fellow Citizens.

8. International Human Rights Law

8.1. Introduction

International human rights law lays down obligations which States are bound to respect. By becoming parties to human rights treaties, States assume obligations and duties under International law to respect, to protect and to fulfil human rights. The obligation to respect means that States must refrain from interfering with or curtailing the enjoyment of human rights. The obligation to protect requires States to protect individuals and groups against human rights abuses. The obligation to fulfil means that States must take positive action to facilitate the enjoyment of basic human rights.

A treaty (or charter, convention or covenant) is a formal agreement between States that defines and modifies their mutual duties towards their own citizens, or between each other as states. Treaties may be either bilateral (between two parties) or multilateral (between more than two parties). A treaty system is based on the agreement of states signing and ratifying the treaty.

- ***Signature*** – a signature to a treaty by a State is the first step to ratification. This shows the state's intention to ratify and become a state party. A State must not act to defeat the purpose of the treaty after signing.
- ***Ratification*** – the process by which a government formally approves the signing of an agreement. The State considers itself a party to the treaty after it has been ratified and is then bound under international law.

Through ratification of international human rights treaties, governments undertake to put into place domestic measures and legislation compatible with their treaty obligations and duties. The domestic legal system, therefore, provides the principal legal protection of human rights guaranteed under international law. Where domestic legal proceedings fail to address human rights abuses, mechanisms and procedures for individual and group complaints are available at the sub-regional, regional and international levels to help ensure that international human rights standards are indeed respected, implemented, and enforced at the local level.

South Africa is a member of the United Nations (UN), African Union (AU) and the Southern Africa Democratic Community (SADC). As such, it has signed or ratified the following relevant international and regional human rights treaties:

- The United Nations Charter (1945).
- The Universal Declaration of Human Rights (1948).
- The International Covenant on Civil and Political Rights (1966).
- The International Covenant on Economic, Social and Cultural Rights (1966).
- The Covenant on the Elimination of All Forms of Discrimination Against Women (1979).
- The United Nations Convention on the Rights of the Child (1989).
- The Standard Minimum Rules for the Treatment of Prisoners (1957).
- The International Convention on the Elimination of All Forms of Racial Discrimination (1965).
- The African Charter of Human and Peoples' Rights (1981).
- The African Charter on the Rights and Welfare of the Child (1989) and
- The Treaty of the Southern African Development Community (1992) as amended.

By signing and ratifying the treaties, South Africa made binding international commitments to adhere to the standards laid down in these universal human rights documents.[21] In doing so, South Africa undertakes to put in place domestic measures such as legislation that is compatible with the treaty obligations and duties.[22]

21. 'Claiming human rights: Guide to international procedures available in cases of human rights violations in Africa – South Africa', accessed from http://www.claiminghumanrights.org/southafrica.html on 4 January 2020.

22. Ibid.

8.2. The application of International human rights law in South Africa

The Constitution is the starting point for determining the role of international law domestically. Section 39 (1) (b) and (c) of the Constitution states that the courts, and other legal bodies, when interpreting the Bill of Rights:

- must consider international law.
- may consider foreign law.

Section 231 of the Constitution states that 'an international agreement binds the Republic after it has been approved by resolution' by the NA and the NCOP, unless it is self-executing, or of a technical, administrative or executive nature.

- A self-executing treaty has a provision stating that it is self-executing. This means that it becomes law in South Africa when it is signed, unless it is inconsistent with the Constitution or an Act of Parliament.
- A non-self-executing treaty that has not been ratified, or even signed, will bind South Africa only if it becomes Customary international law. Customary international law is law in South Africa unless it is inconsistent with the Constitution or an Act of Parliament.[23]

Essentially, for treaty law to become part of domestic law, there are two systems:

- *Monism* – there is no need for domestic legislation for international law to take direct effect. The act of signing automatically incorporates international law into domestic law.
- *Dualism* – the international law provisions can be enforced only when formally incorporated into domestic law.

South Africa is a dualist state, that is, it uses a combination of the two systems. International agreements of a technical, administrative or executive nature that do not require ratification,will bind the Republic. Other International agreements have to be enacted into law by national legislation (except for self-executing provisions that have been approved by Parliament and are consistent with South African law).

Finally, section 233 provides that, when interpreting legislation, courts: 'must prefer any reasonable interpretation of the legislation that is consistent with international law over any alternative interpretation that is inconsistent with international law'. While section 233 gives greater weight to international law, the court will take into account whether the relevant international law is binding on South Africa. Furthermore, where international law is in direct conflict with the Bill of Rights, the courts will not uphold it.

8.3. When can international Law be Used as a Legal Remedy

The use of international law in litigation is crucially important in a young democracy with very few domestic cases as precedents to guide the courts. Cases may refer to the prevailing international opinion on the interpretation of the international agreement. There may also be cases where the international obligations of South Africa may be the subject of litigation. Individuals and interested parties can use the international human rights systems as a way of establishing and developing rights. Where South Africa is a signatory to an international treaty or a regional body that permits individual complaints, the individual must have exhausted domestic remedies (unless the remedy is ineffective, or the remedy will take an unreasonable length of time). In other words, you must try to take up your case through South African courts first before using complaint procedures under international law.[24]

Given that the South African Constitution compels courts to have regard to international law in applying the Bill of Rights, it will remain an important aspect of the interpretation of rights domestically. Using the international or regional system to advance rights on the other hand is more complex and time-consuming. One needs to have exhausted all potential domestic avenues, and have the capacity to engage the international mechanisms. Where there are strong institutions within countries that support the protection of human rights such as an independent judiciary, national human rights commissions and public protectors, the need to use the international institutions to protect rights is weaker. However, the international and regional, sub-regional? bodies are especially valuable for those countries without strong independent domestic institutions.

23. Section 232 of the Constitution.

24. International Justice Resource Centre 'Exhaustion of Domestic Remedies in the African Human Rights System' accessed from https://ijrcenter.org/wp-content/uploads/2017/11/7.-Exhaustion-of-Domestic-Remedies-African-System.pdf on 13 October 2020.

CHAPTER 2

LAW IN THE CONTEXT OF HIV AND TB

1. The Link Between HIV and TB and the Law

The Human Immunodeficiency Virus (HIV) and Tuberculosis (TB) have been described as co-epidemic.[1] This is because, since, the beginning of the HIV epidemic, the number of TB cases has more than 'doubled in countries where the number of HIV infections is high.'[2] Fortunately, there is now wider availability of diagnostic tools and life-saving treatment for both diseases. Those who were born with HIV are surviving into adulthood, while others are members of the ageing population of people living with HIV (PLHIV).[3] However, despite all reported successes in the fight against TB and HIV, HIV and TB -related stigma and discrimination continue to undermine the efforts in prevention, treatment and care for both diseases all over the world.[4]

Unlike HIV, TB is the top infectious disease killer in the world and as global threat from multidrug-resistant TB continues to grow, the ethical and legal issues around TB remain largely neglected in national TB programs and research agendas.[5] PLHIV and person with TB (PWTB) experience infringements of their human rights on a daily basis. In many cases they lack access to effective testing and treatment, face discrimination in employment and healthcare settings, and those with TB are unnecessarily detained and isolated against their will.[6]

An enabling legal environment can play a vital role in the well-being of PLHIV and PWTB. 'Good laws, fully resourced and rigorously enforced, can widen access to prevention and healthcare services, improve the quality of treatment, enhance social support for people affected by the epidemic'.[7] The law and social environments can discriminate and isolate PLHIV and people at higher risk of exposure to HIV and PWTB, for example, sex workers and their clients, men who have sex with men, people who inject drugs, transgender persons and migrant population.[8] Consequently, questions about HIV and TB are often 'translated into human rights issues, which are [often] negotiated through the legal systems'.[9] As such, new innovative approaches in the legal and policy development are needed to address the social, economic, and structural factors driving the epidemics.

2. Stigma and Discrimination

'Communicable diseases spread from one person to another or from an animal to a person often via airborne viruses or bacteria, but also through blood and other bodily fluids'.[10] The challenge that comes with communicable diseases is stigma and discrimination. Fear of the unknown creates justification for the exclusion and disenfranchisement of those with medical conditions for which there seem to be no apparent remedy'.[11] Often people with leprosy, syphilis, herpes and hepatitis have suffered discrimination as those with PLHIV - a blood-borne communicable disease and TB - an airborne communicable disease, do today.

The fight against the two co-epidemic is a fight against fear, prejudice, ignorance and the denial of public resources, and can be considered to be battle against some of the most critical violations of human rights.[12] Unfortunately, '[t]ime and experience has *[sic]* also revealed that despite the development of cures for diseases once thought to be terminal [like HIV], the shadow cast by disease related

1. International Federation of Red Cross and Red Crescent Societies: 'The link between tuberculosis and HIV' accessed from https://www.ifrc.org/en/what-we-do/health/diseases/tuberculosis/the-link-between-tuberculosis-and-hiv/ on 27 April 2020.
2. Ibid.
3. UNAIDS 'AIDS 2014: Addressing the needs of people who have lived with HIV for more than 20 years', accessed from http://www.unaids.org/en/resources/presscentre/featurestories/2014/july/2014072220yearsp on 13 March 2020.
4. NP Simelela and WDF Venter 'A brief history of South Africa's response to AIDS', SAMJ 104:3 (2014): 249 at p. 251.
5. Dingake OBK. Human Rights, TB, Legislation, and Jurisprudence. *Health and Human Rights.* (2017): 19(1) at p.305.
6. Ibid
7. Global Commission on HIV and the Law 'HIV and the law: Risks, rights and health' (2012) at p. 11.
8. See the National Strategic Plan on HIV, STIs and TB 2012–2016 at pp. 25–26.
9. WB Rubenstein, R Eisenberg and LO Gostin *The Rights of People who are HIV Positive: The Authoritative ACLU Guide to the Rights of People Living with HIV Disease and AIDS* (Carbondale: Southern Illinois University Press, 1996) at xiii.
10. See: http://www.globalhealth.gov/global-health-topics/communicable-diseases accessed on 13 March 2020.
11. J Williams, D Gonzalez-Medina, Q Le 'Infectious diseases and social stigma' *ATI – Applied Technologies & Innovations* 4(1) (April 2011): 58–70 at p. 58.
12. M Chetty 'Human rights, access to health care and AIDS' *SAJHR* 9 (1993): 71.

stigma is not easily lifted with increased knowledge and medical technology'.[13]

2.1. Defining Stigma and Discrimination

Stigma is enacted through discrimination which is defined as the 'unfair and unjust treatment of an individual based on his or her real or perceived status'.[14] People who are infected with TB and HIV often experience a unique overlapping double stigma.[15] Often, being infected with TB sends a signal or a perception that the person is also infected with HIV. Similar to HIV, TB has:[16]

> 'disproportionately affected people marginalized by poverty and social exclusion and those living in sub-standard conditions in prisons and in the community. These same factors of marginalization, many of which are related to unrealized human rights, can impede people's access to TB prevention, diagnosis and treatment.'[17]

TB stigma is grounded in 'social structures, human behaviour and belief systems'.[18] In an attempt to understand TB stigma, seven domains of public stigma have been identified, namely, 'social distance, traditional prejudice, exclusionary sentiments, negative affect, treatment carryover, disclosure carryover and perceptions of dangerousness.'[19] The seven domains of public stigma have been described as follows:[20]

- Social distance is when someone tries to avoid a person with TB (PWTB).
- Traditional prejudice is when someone stereotypes people with TB believing all people with TB are less valuable.
- Exclusionary sentiments refers to the wish to separate PWTB from everyone else, or deny them their rights.
- Negative affect refers to emotional reactions such as disgust or hatred toward PWTB.
- Treatment carryover is when people are afraid of people knowing that they were treated for TB in the past. This is the perceived need for secrecy that may linger after a person recovers.
- Disclosure carryover is when people are afraid of the reactions they would get if they were known to have TB.
- Perceptions of dangerousness is the idea that PWTB somehow represent a risk to society

Similar to HIV related stigma, TB related stigma leads to discrimination of PWTB, which also has a negative effect of reducing health seeking behaviour that further exacerbates transmission. For example, PWTB would fear stigmatization and not wear masks.

Discrimination is a form of differentiation 'based on attributes or characteristics which have the potential to impair the fundamental dignity of persons as human beings, or to affect them seriously in a comparably serious manner'.[21] HIV and TB-related discrimination often takes the form of hostility and prejudice against PLHIV and PWTB (as well as their partners and families), denying them equal access to essential services, denying them an opportunity to enjoy their lives in the community they live in, in their place of work and in other settings.[22]

13. Williams et al. (fn. 34) at p.58.
14. UNAIDS 'Fact sheet: Stigma and discrimination' (December 2003), accessed from http://data.unaids.org/publications/Fact-Sheets03/fs_stigma_discrimination_en.pdf.
15. See *Hoffmann v South African Airways* 2001 (1) SA 1.
16. Background Paper on Tuberculosis and Human Rights Prepared for a side event on human rights and TB Preceding the UN General Assembly hugh -level meeting on ending TB" (24 September 2018) at p. 2.
17 Ibid.
18. KNCV Tuberculosis Foundation: " TB Stigma Measurement Guidance" accessed on https://www.challengetb.org/publications/tools/ua/TB_Stigma_Measurement_Guidance.pdf at p.24.
19. Pescosolido BA, Martin JK, Lang A, Olafsdottir S. Rethinking theoretical approaches to stigma: A Framework Integrating Normative Nuances on Stigma (FINIS). Soc Sci Med. 2008;67:431–40 accessed from https://www.challengetb.org/publications/tools/ua/TB_Stigma_Measurement_Guidance.pdf at p.17.
20. Ibid.
21. I Currie and J de Waal The Bill of Rights Handbook 6th edn (Cape Town: Juta, 2013) at p. 223, quoting *Harksen v Lane NO* 1998 (1) SA 300 (CC) at para. 46.
22 M Dos Santos, P Kruger, SE Mellors, G Wolvaardt and E van der Ryst 'An exploratory survey measuring stigma and discrimination experienced by people living with HIV/AIDS in South Africa: The People Living with HIV Stigma Index' *BMC Public Health* 14:80 (2014), DOI 10.1186/1471-2458-14-80, at p. 1.

2.2. Causes and Forms of HIV and TB related Stigma and Discrimination

There are multiple causes of HIV and TB -related stigma. The most cited are a lack of understanding of HIV and TB including misconceptions about how the diseases are transmitted; lack of access to treatment; irresponsible media reporting; fear of AIDS and its incurability; and issues of morality fuelled by prejudice and fear relating to socially sensitive issues such as sex and sexuality, disease, death, and drug use.[23]

The most common forms of HIV stigma and discrimination are 'physical and social isolation from family, friends and community; being kicked out of one's family, house, rented accommodation, school, and community groups; gossip, name-calling and insults; judging, blaming and condemnation; loss of rights and decision-making power; loss of employment; impaired access to treatment and care; and violence on disclosure of HIV'.[24]

The common forms of TB related stigma and discrimination is rooted in poverty, legal, structural, and social barriers leading to the denial of patients access to TB services of the highest quality.[25] A human rights-based approach to TB calls for the establishment and protection of the rights of people with and vulnerable to TB, namely, the rights to life, right to health, non-discrimination, right to privacy, liberty of movement, housing, food, water, including access to the most recent treatments and diagnostic tools.

2.3. Effects of Stigma and Discrimination on Human Rights

Stigma can leads to discrimination and other violations of human rights which affect the well-being of PLHIV and PWTB in fundamental ways such as, access to healthcare, work, education, and freedom of movement, among other rights. Therefore, not only is HIV and TB-related discrimination a human rights violation, but it is also necessary to address such discrimination and stigma in order to achieve public health goals and overcome the epidemic. Ideally, people should be able to seek and receive voluntary and confidential counselling and testing to identify their HIV status without fear of repercussions. Those who test HIV-negative should receive prevention counselling to be able to stay negative. Those who test HIV-positive should receive available treatment and care, and prevention counselling to protect others from infection and themselves from reinfection. PLHIV and TB should be able to live openly and experience compassion and support within their communities. This open example personalizes the risk and experience to others, thereby aiding prevention, care and treatment efforts.

3. Stigma and Discrimination in the Context of Key and Vulnerable Populations

Often people who are socially marginalised are also widely stigmatised and discriminated against. Such people include sex workers and their clients, the LGBTI persons, injecting drug users, men who have sex with men, people with disabilities, migrant populations, and inmates. Men and women may experience different forms and intensities of stigma and discrimination. Women are 'particularly vulnerable to stigma, and may be subject to violence, one of the harshest and most damaging forms of stigma'.[26]

The following are examples of the stigma and discrimination experienced by key and vulnerable populations:

3.1. Women

In some places, women have been shown to face greater TB-and HIV related stigma than men, at times because HIV is often wrongly perceived to be related to sexual promiscuity. Sexual and reproductive health is also a key aspect of women's right to health. Therefore, women's lack of control over and to decide to freely and responsibly on matters related to their sexuality, including their sexual and reproductive health, inequality due to patriarchy, lack of education and information and violence make them more vulnerable to HIV and TB.

See detailed discussion in sub-chapter 4.1.

23. Ibid at p. 2.

24. R Smart 'HIV/AIDS-related stigma and discrimination', accessed from http://new.iiep.unesco.org/fileadmin/user_upload/Training/HIV_AIDS/HIVAIDS_1.4_ENG.pdf on 23 March 2020.

25. Dingake OBK. Human Rights, TB, Legislation, and Jurisprudence. *Health and Human Rights*. (2017): 19(1) at p.305

26. L Nyblade, A Stangl, E Weiss and K Ashburn 'Combating HIV stigma in health care settings: What works?' *Journal of the International AIDS Society* 12:15 (2009), DOI 10.1186/1758-2652-12-15, at p. 2. See also the NSP 2012–2016.

3.2. Children

Children living with HIV often experience stigma, discrimination and violations of their rights, including discrimination within their communities and in their access to health-care services. Children are sometimes subjected to HIV testing without their voluntary and informed consent, or to having their rights to confidentiality breached by health professionals.

There are several reasons why offering healthcare treatment to children is complex. Firstly, testing children highlights the possibility of perinatal transmission of HIV. Testing children often raises serious implications for the child's mother and her own HIV status. Parents are often apprehensive about subjecting their children to HIV tests, especially when they are unsure of their own status. Parents may also fear being stigmatised and discriminated against if their child is HIV-positive and his or her status becomes known.

The challenge with adolescents is slightly different, in that such children may have concerns that testing will inadvertently reveal their at-risk behaviours to parents. They may also fear facing family or social disapproval for having engaged in underage sexual activity leading to HIV infection. However, many adolescents do not have the basic knowledge and skills to protect themselves from exposure to HIV, and have insufficient access to information, HCT, condoms, and treatment and care for sexually transmitted infections.[27] Access to independent HIV testing, treatment and care for adolescents and young people is limited by laws and policy, including age of consent requirements that limit their access to services. For many children, access to HIV treatment and care is limited by social, medical, systemic and economic barriers, including the failure to implement appropriate systems and strategies for early diagnosis and treatment for children. Furthermore, lack of birth registration for children, particularly orphans and other vulnerable children, contributes to hindering their access to health and social services.[28]

See detailed discussion in sub-chapter 4.2.

3.3. Prisoners (Inmates) and Others in Custody of the State

People in prison and pre-trial detention face high TB risk because of overcrowding and poor ventilation in their living quarters. In many parts of the world, healthcare in prison is not confidential, and those seeking services are discriminated against on the basis of HIV status, non-gender conforming behaviours, sexual orientation or gender identity. These views are fuelled by a variety of factors, including ignorance about HIV and TB transmission routes. Discrimination by healthcare workers prevents many people from being open and honest when they seek medical help more specifically in prisons. It also deters people from seeking, using and adhering to HIV prevention and treatment services.

See detailed discussion in sub-chapter 4.3.

3.4. Foreign Nationals

Despite the international obligations placed on states to ensure that they adhere to international standards to protect the human rights of all foreign nationals, foreign nationals continue to experience conditions associated with HIV and TB risk while also facing discrimination, lack of legal documentation and other barriers to health services. Foreign nationals often do not know their rights or have the means to seek legal services to help protect their rights. They may face harassment from police or in the community that pushes them underground and thus further from health services.

See detailed discussion in sub-chapter 4.4.

3.5. Sex Workers

Sex workers living with HIV may not feel it is safe to disclose their status to friends or other workers, and may not seek community support and programmes for fear of discrimination. Sex workers who choose to disclose their status, or whose status is disclosed to the community without their consent, may find that programmes for sex workers or programmes for people living with HIV are not safe or welcoming environments for them.[29]

27. See Van Rooyen, H E; Strode, A E and Slack, C M. HIV testing of children is not simple for health providers and researchers: Legal and policy frameworks guidance in South Africa. *SAMJ, S. Afr. med. j.* [online]. 2016, vol.106, n.5 [cited 2020-03-02], pp.451-453.

28. Global Commission on HIV and the Law, HIV and the Law (New York: Global Commission on HIV and the Law, 2012), 64

29. Community guide on stigma and discrimination experienced by sex workers living with HIV.

3.6. Men who have Sex with Men (MSM)

While the South African Constitution does not discriminate against anyone on grounds of sexual orientation, in reality, gay men and other MSM continue to be stigmatised and discriminated largely because their behaviour is perceived to deviate from social norms, hence homoprejudice is widespread. In a study conducted in South Africa's Gauteng province in 2016, 11% of the 852 lesbian, gay, bisexual or transgender study respondents reported having experienced heterosexism when accessing healthcare.[30] Widespread discrimination, prejudice and moral-loading on the part of healthcare workers result in substandard healthcare provision and intensify Key Populations' fear of seeking services.

See detailed discussion in sub-chapter 4.6.

3.7. People who Inject Drugs

People who inject drugs face high TB risk independent of their HIV status, though HIV increases their risk. In many instances, people who inject drugs share equipment and engage in other practices with direct TB risk. In addition, people who inject drugs are likely to be in prison or pre-trial detention due to harsh drug laws. Criminalization of minor drug offenses remains a negative part of drug laws in most countries and impedes access to health services and information for those who use drugs. As such, this population fear health services because of stigma or the possibility that health workers will turn them to the police.

See detailed discussion in sub-chapter 4.7.

4. Constitutional Rights and Principles that Protect PLHIV and PWTB

4.1. Constitutional Protection and Principles

The South African Constitution is founded on the values of 'Human dignity, the achievement of equality and the advancement of human rights and freedoms'.[31] As is the case with people who are uninfected, the rights of PLHIV and PWTB to equality, non-discrimination, human dignity, privacy and confidentiality, and healthcare stem 'from a variety of international and regional human rights instruments, and from domestic constitutional or statutory provisions'.[32]

4.2. Principles of Equality and Human Dignity

Section 9(1) of the Constitution provides that *'Everyone is equal before the law and has the right to equal protection and benefit of the law'*. In terms of section 9(2) equality *'includes the full and equal enjoyment of all rights and freedoms'* and, *'[t]o promote the achievement of equality, legislative and other measures designed to protect or advance persons, or categories of persons, disadvantaged by unfair discrimination may be taken'*.

Section 9 does not prohibit discrimination but prohibits unfair discrimination.[33] Unfair discrimination has been defined as *'differential treatment that is hurtful or demeaning. It occurs when law or conduct, for no good reason, treats some people as inferior or incapable or less deserving of respect than others'*.[34] Section 9(3) prohibits unfair discrimination by the state on the grounds of race, gender, sex, pregnancy, marital status, ethnic or social

30. Hate crimes against LGBT people in South Africa,2016.

31. S 1(a) of the Constitution of the Republic of South Africa, 1996.

32. EJ Uko 'Legal rights of people vulnerable to HIV/AIDS in Africa' Codicillus 45 (2004): 32 at p. 34.

33. For analysis of the concept of discrimination by the South African Constitutional Court, see *Pretoria City Council v Walker* 1998 (2) SA 363 (CC); Prinsloo v Van der Linde and another 1997 (3) SA 1012 (CC); President of the Republic of South Africa v Hugo 1997 (4) SA 1 (CC); Harksen v Lane NO and others 1998 (1) SA 300 (CC); Larbi-Odam and others v Member of the Executive Council for Education (North-West Province) and another 1998 (1) SA 745 (CC).

34. Op cit note 21 at p. 223.

origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth.[35]

Although HIV status is not listed in section 9(3) as one of the grounds on which an individual may not be discriminated against, *Brink v Kitshoff NO*,[36] decided in terms of the interim Constitution, provided scope for not confining discrimination to only the listed grounds but for interpreting the equality clause more broadly. In this case, the Constitutional Court held that the equality clause *'was adopted in the recognition that discrimination against people who are members of disfavoured groups can lead to patterns of group disadvantage and harm. Such discrimination is unfair: it builds and entrenches inequality amongst different groups in our society'*.[37] The court further held that, *'[a]lthough the most visible and most vicious pattern of discrimination [in South African history] has been racial, other systematic motifs of discrimination were and are inscribed in [South Africa's] social fabric. In drafting section 8 [section 9 in the 1996 Constitution], the drafters recognised that systematic patterns of discrimination on grounds other than race have caused, and may continue to cause, considerable harm. For this reason section 8(2) [section 9(3) of the 1996 Constitution] [listed] a wide, and not exhaustive, list of prohibited ground of discrimination.'*[38]

In *Hoffman vs South Africa Airways*[39] SAA, an organ of state, had a policy that permitted it to not hire HIV positive persons as cabin attendants. Hoffman, an SAA cabin attendant, challenged the constitutionality of the policy, arguing that it violated his constitutional right to equality. SAA stated that the reason for implementing this policy was to promote passenger health and safety and that people living with HIV were a bad training investment due to their limited life expectancy.[40] The right to equality includes the prohibition of unfair discrimination.[41] The Constitutional Court held that HIV was not a "disability," but found nonetheless that discrimination on this basis would constitute an infringement of dignity, as it was discrimination based on a person's medical health. Discrimination on the basis of HIV status, as part of discrimination on the basis of illness, was held to be analogous to the grounds of unfair discrimination listed in the Constitution and was found, therefore, to be unfair. The Constitutional Court went on to hold that PLHIV, "have been subjected to systematic disadvantage and discrimination. They have been stigmatised and marginalised. Society's response has forced many of them not to reveal their HIV status for fear of prejudice. This in turn has deprived them of the help they would otherwise have received. People who are living with HIV/AIDS constitute one of the most vulnerable groups in society."[42]

In general, unfair discrimination has the effect of fundamentally impairing the dignity of human beings; hence the right to equality and the right to dignity are intertwined. The right to dignity is found in section 10 of the Constitution which states that *'[e]veryone has inherent dignity and the right to have their dignity respected and protected'*. The constitutional protection of dignity for PLHIV requires every member of society, government agencies and private institutions to 'acknowledge the value and worth of all individuals as members of society'.[43] However, as the court noted in the *Hoffmann* case, PLHIV constitute a minority and [s]ociety has responded to their plight with intense prejudice. Notwithstanding the availability of compelling medical evidence as to how this disease is transmitted, the prejudices and stereotypes against HIV positive people still persists. In view of the prevailing prejudice against HIV positive people, any discrimination against them can be interpreted as a fresh instance of stigmatisation and

35. S 9(3) provides that 'The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth'.

36. 1996 (4) SA 197 (CC). In this case the constitutionality of s 44(1) and (2) of the Insurance Act 27 of 1943, which deprived married women in certain circumstances of all or some of the benefits of life insurance policies ceded to them or made in favour of their husbands, was challenged.

37. Ibid. at para. 42.

38. Ibid. at para. 41.

39. 2001 (1) SA 1 (CC) .

40. Ibid.

41. See section 9(3) of the Constitution of the Republic of South Africa, 1996.

42. Op cit note 36 at para 28.

43. National Coalition for Gay and Lesbian Equality and another v Minister of Justice and others 1998 (12) BCLR 1517 (CC), 1999 (1) SA 6 (CC) at para.28.

this constitutes an assault on their dignity. The impact of discrimination on HIV positive people is devastating.[44]

Equality and human dignity are inseparable as they entail that everyone be treated as equally worthy of respect.[45] HIV and TB related stigma and discrimination are inconsistent with human dignity as it has a significant negative impact on the quality of life of PLHIV and PWTB.

4.3. The Right to Privacy

Section 14 of the Constitution provides that every individual in South Africa enjoys a right to privacy. This includes the right not to have the privacy of one's private Communications infringed. Information about a person's health is very sensitive, particularly for PLHIV and PWTB because they live with a condition that is highly stigmatised.[46] It is vital to the achievement of public health goals that PLHIV and PWT are able 'to control whether, and in what circumstances, information about their health status is disclosed'.[47] Persons who fear that disclosure of their health status will lead to stigma, prejudice and discrimination are less likely to disclose their health status and seek treatment.

In Jansen *van Vuuren and another NNO v Kruger*,[48] a doctor discussed the HIV status of his patient with colleagues during a game of golf. The news of the patient's medical condition spread throughout the small community. The patient lodged a civil claim for compensation from his doctor for breaking his right to confidentiality. The court confirmed that 'The duty of a physician to respect the confidentiality of his patient is not merely ethical but is also a legal duty recognised by the common law'.[49] The case that underlined the importance of the constitutional right to privacy for PLHIV is *NM and others v Smith and others*[50] where the Constitutional Court decided that the respondents' publication of the applicants' names and HIV status without their consent violated the applicants' right to privacy which resulted in impairment of their dignity. Given the stigma that is attached to HIV, disclosure of a person's HIV status may lead to that person's being ostracised by family or by the community.

The right to privacy in the context of HIV and TB is discussed in detail in Chapter 3.

4.4. The Right to Healthcare

Access to healthcare contributes to improvement in the health of PLHIV and PWTB improves their life expectancy. Fundamental to the right to access to healthcare is equal access and non-discrimination.[51] Thus, enjoyment of the right to health means obtaining access to treatment, care and support from health-care facilities. Section 27(1)(a) of the South African Constitution provides that '[e]veryone has the right to have access to . . . healthcare services, including reproductive healthcare'. To achieve the 'progressive realisation' of this right '[t]he state must take reasonable legislative and other measures, within its available resources'.[52]

Therefore the test for state compliance with this positive duty is whether its efforts to realise this right are reasonable.[53] To this end, a policy that excludes a significant number of people is more likely not to be reasonable. Further, where the State pleads resource constraints, the court will be slow to interfere with rational decisions taken by the executive to provide for socio-economic rights.[54]

44. Hoffmann v South Africa Airways (fn. 53 above) at para. 28, citing C Ngwena 'HIV in the workplace: Protecting rights to equality and privacy' SAJHR 15 (1999): 513 at p. 514.
45. Op cit note 21 at p. 252.
46. See Rubenstein et al. (fn. 10 above) at p. 40.
47. A Quan and C Ward 'All of us count: Developing policy and advocacy skills for the involvement of affected communities in responding to HIV/AIDS' at p. 28, accessed from http://www.hivpolicy.org/Library/HPP000130.pdf on 24 April 2020.
48. 1993 (4) SA 842 (A).
49. Ibid. at p. 850.
50. 2007 (5) SA 250 (CC).
51. M San Giorgi The Human Right to Equal Access to Health Care (Antwerp: Intersentia, 2012) at p. 54.
52. S 27(2) of the Constitution.
53. Op cit note 21 at p. 573.
54. Soobramoney v Minister of Health (Kwazulu-Natal) 1998 (1) SA 765 (CC)

The South African Constitutional Court's approach to positive duties that arise from socio-economic rights is different from its approach to negative duties. For example, in *Minister of Health and others v Treatment Action Campaign and others*[55] the court had to decide whether the right to healthcare required the state to provide beyond pilot sites the antiretroviral drug Nevirapine to HIV-positive pregnant mothers to prevent mother-to-child transmission of HIV. It confirmed that the Constitution provides for enforceable and justiciable socio-economic rights[56] and requires the state 'to devise and implement within its available resources a comprehensive and co-ordinated programme to realise progressively the rights of pregnant women and their newborn children to have access to health services to combat mother-to-child transmission of HIV'.[57] The South African government is obliged to implement legislation or government policy to meet its constitutional duty in terms of section 27 of the Constitution.

5. Statutory Protections for PLHIV and PWTB

Section 9(4) of the South African Constitution has paved the way for the enactment of specific legislative protection to prevent or prohibit unfair discrimination. By requiring the state to enact legislation 'to prevent or prohibit unfair discrimination', it has obliged the state to deal with the various forms of discrimination against PLHIV by enacting legislation to:

- prevent unfair discrimination against PLHIV and PWTB and those affected by HIV in employment, healthcare, HIV testing, insurance and education and in state and other institutions;
- ensure that the rights of PLHIV and PWTB are respected; and
- ensure that adequate provision for monitoring and enforcing of human rights are put in place.

Below is a list of statutes together with the relevant sections that directly protect the rights of PLHIV and PWTB.

5.1. Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000

The Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000, commonly known as PEPUDA or as the Equality Act, seeks to fulfil the constitutional mandate to prohibit unfair discrimination. Section 1 of the Act defines 'discrimination' as any act or omission, including a policy, law, rule, practice, condition or situation which directly or indirectly –

a. Imposes burdens, obligations or disadvantages on; or
b. Withholds benefits, opportunities or advantages from, any person on one or more of the prohibited grounds.

Although HIV is not listed as a prohibited ground of discrimination,[58] section 34 of the Act provides for a directive principle on HIV, nationality, socio-economic status and family responsibility and status. Section 34(1) states that 'In view of the overwhelming evidence of the importance, impact on the society and link to systemic disadvantage and discrimination on the grounds of HIV/AIDS status, special consideration must be given to the inclusion of these grounds in paragraph (a) of the definition of "prohibited grounds" by the Minister'.

The schedule to the Equality Act provides an illustrative list of unfair practices in the following sectors:

- Labour and employment.
- Education.
- Healthcare services and benefits.
- Housing, accommodation, land and property.
- Insurance services.
- Pensions.
- Partnerships.
- Professional bodies.
- Provision of goods, services and facilities.
- Clubs, sports and associations.

55. 2002 (5) SA 721 (CC).

56. Ibid. para. 25.

57. Ibid. para. 135.

58. See s 1 of the Equality Act s.v. 'prohibited grounds'.

5.2. Employment Equity Act 55 of 1998

Section 6(1) of the Employment Equity Act 55 of 1998 (EEA)[59] provides that no person may unfairly discriminate against an employee, in any employment policy or practice, on the basis of the employee's HIV status. Section 7(2) read with Section 50(4) of the EEA prohibits medical testing of an employee to determine her or his HIV status unless the Labour Court has declared such testing justifiable. A Code of Good Practice on HIV in the World of Work was gazetted in 2012 in terms of the EEA. Employers can use this code in developing internal HIV and AIDS workplace policies and programmes.

5.3. Children's Act 38 of 2005

The Children's Act 38 of 2005 was enacted 'to fully recognise the rights of the child to participate in decisions affecting them, clarify their right to privacy in respect of disclosure of HIV status, lower the age of consent to promote access to healthcare services, and allow caregivers (e.g. grannies and aunts) to consent to health treatment for young children in their care'.[60] It gives effect to section 28 of the Constitution which requires the best interests of the child to be given a primary consideration in all matter affecting children. Section 130 of the Children's Act provides for the HIV-testing of children and sets out rules regarding the child's capacity to consent to an HIV test. Section 132 of the Children's Act requires that children be given correct pre- and post-test counselling by a trained person and section 133 of the Children's Act that information on a child's HIV status be kept confidential. A child's right to choose whether or not to disclose her or his HIV status is rooted in the constitutional rights to privacy and physical integrity.[61]

5.4. Criminal Procedure Second Amendment Act 85 of 1997 and Criminal Law Amendment Act 105 of 1997

Other statutory protections that regulate issues related to HIV are the Criminal Procedure Second Amendment Act 85 of 1997 which makes the granting of bail more difficult where the suspected sexual offender is known to be HIV positive and the Criminal Law Amendment Act 105 of 1997 provides for harsher sentencing of HIV positive offenders who commit sexual assault.

In the case of *EN and Others v. Government of RSA and Others*[62] *commonly referred to as the* Westville prison antiretroviral access case is a good example of jurisprudence which ensured the constitutional right to access to healthcare for men in prison. A total of 15 inmates at Westville Prison in KwaZulu-Natal were helped by the Aids Law Project (ALP) to access the necessary antiretroviral treatment through a court order in 2006. The ALP requested the removal of restrictions that stopped prisoners from accessing the treatment and the court ruled in its favour. This case serves as a good example of civil society making use of legislation to ensure the right to access to healthcare by every South African. The ALP successfully managed, through the Durban High Court, to ensure that the prisoners had access to healthcare services in the form of ART. The Department of Correction Services had intended to delay implementing the court order which instructed it to provide an action programme of how it was going to provide ART to the prisoners by applying for leave in order to make an appeal against the judgement but the judge quoted Judge Yacoob in the Grootboom case:[63]

59. As amended by s 3(a) of the Employment Equity Amendment Act 47 of 2013.

60. L Jamieson and L Lake Children's Act Guide for Health Professionals 5th edn (Cape Town: Children's Institute, University of Cape Town, 2013) at p. 13.

61. Ibid.

62. 2006 (6) SA 575 (D).

63. Government of the Republic of South Africa and Others v Grootboom and Others 2001 (1) SA 46 (CC).

'The formulation of a programme is only the first stage in meeting the State's obligation. The programme must also be reasonably implemented. An otherwise reasonable programme that is not implemented reasonably will not constitute compliance with the State's obligations'.[64]

Judge Yacoob's interpretation of Section 27 of the Constitution regarding healthcare, food, water and social security was the following:[65]

(1) Everyone has the right to have access to (a) healthcare services, including reproductive healthcare; (b) sufficient food and water; and (c) social security, including, if they are unable to support themselves and their dependants, appropriate social assistance. (2) The State must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights. (3) No one may be refused emergency medical treatment.

The Durban High Court rejected the appeal and not only ordered the Department of Correctional Services to immediately provide antiretroviral treatment to the prisoners in need at Westville Prison, but also interpreted the delay by Government to submit a plan of action as a disturbing contempt of court. Thereafter, the Department of Correctional Services complied with the court's order.[66]

6. International Human Rights and Principles that Protect PLHIV and PWTB

6.1. International Law and the Right to Health

The right to health was first expressed as a right in the *Universal Declaration of Human Rights* (UDHR) in 1948. Article 25 provides for the right in a very broad sense that includes food, clothing, housing, medical care and necessary social services. In this articulation of the right, we see how interconnected various rights and aspects of our life are. In communities that live in poverty, access to medicines alone, in the absence of sanitation, water or food will not necessarily improve the health status of people who live there.

A further provision that is relevant to the right to healthcare is Article 27 of the UDHR . It provides that: *"Everyone has the right... to share in scientific advancement and its benefits."* Innovation in medicines and technology is important in protecting and promoting the right to healthcare. However, the cost of innovation and the patent regime has often been an obstacle to accessing new medicines and technology, and therefore an obstacle to the enjoyment of the right contained in Article 27.

The International Guidelines on HIV and Human Rights (UNAIDS Guidelines) were adopted by the OHCHR and UNAIDS in 1998. The UNAIDS Guidelines give states clarity on their approach to the epidemic that is meant to foster a consciousness of HIV in all branches of government. Guideline 6, for example, provides that: 'States should enact legislation to provide for the regulation of HIV-related goods, services and information, so as to ensure widespread availability of qualitative prevention measures, adequate HIV prevention and care information and safe and effective medication at an affordable price.'

The guidelines highlight the need for general anti-discrimination laws to cover HIV. Access to HIV/AIDS-related treatment is fundamental to realising the right to health. Preventative, curative and palliative care of HIV/AIDS, and related opportunistic infections and conditions, should be included. Access to medication is one element of comprehensive treatment, care, and support. International co-operation is vital in realising equitable access to treatment, care and support for all in need.

In June 2001, 189 member states at the United Nations General Assembly Special Session (UNGASS) on HIV adopted the *Declaration of Commitment on HIV* without reservation. The Declaration contains the commitment of leaders of governments and states to take action on HIV in a number of areas, including: leadership, prevention, care, support and treatment, HIV and human rights.

64. Ibid at para 42.

65. Ibid para 19 .

66. Chibango, Conrad. (2013). South Africa's HIV and AIDS Policy and Legislation: An Analysis. Greener Journal of Medical Sciences. Volume 3. 240-250. 10.15580/GJMS.2013.6.052413638 at p. 10.

In the preamble, member states recognised the HIV epidemic as a global economic, social and development crisis. They agreed on the need to address HIV by strengthening respect for human rights and, in particular, the rights of those most vulnerable to infection, including women and children. Making commitments on HIV real

- Realisation of human rights and fundamental freedoms for all is essential to reducing vulnerability to HIV.
- Respect for the rights of people living with HIV drives an effective response.

The following are other relevant International and regional human rights instruments that contain key human rights principles essential to effective responses to HIV and TB:

The International Covenant on Economic, Social and Cultural Rights: Article 12: The right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

African Charter on Human and People's Rights[67] **Article 16 1**. Every individual shall have the right to enjoy the best attainable state of physical and mental health. States parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.

6.2. State Obligations to protect PLHIV and PWTB under International Law

Non-discrimination and equality are fundamental human rights principles and critical components of the right to health. The International Covenant on Economic, Social and Cultural Rights (art. 2 (2)) identify the following non-exhaustive grounds of discrimination: race, colour, sex, language, religion, political or other opinion, national or social origin, property, disability, birth or other status. According to the Committee on Economic, Social and Cultural Rights, "other status" may include health status or sexual orientation.

States have an obligation to prohibit and eliminate discrimination on all grounds and ensure equality to all in relation to access to healthcare and the underlying determinants of health. The International Convention on the Elimination of All Forms of Racial Discrimination (article 5) also stresses that States must prohibit and eliminate racial discrimination and guarantee the right of everyone to public health and medical care.

Non-discrimination and equality further imply that States must recognize and provide for the differences and specific needs of groups that generally face particular health challenges, such as higher mortality rates or vulnerability to specific diseases.

The obligation to ensure non- discrimination requires specific health standards to be applied to particular population groups, such as women, children or persons with disabilities. Positive measures of protection are particularly necessary when certain groups of persons have continuously been discriminated against in the practice of States parties or by private actors.

Along the same lines, the Committee on Economic, Social and Cultural Rights has made it clear that there is no justification for the lack of protection of vulnerable members of society from health-related discrimination, be it in law or in fact. Hence even at times of economic hardship, vulnerable members of society must be protected, for instance through the adoption of relatively low- cost targeted programmes.[68]

7. Conclusion

As governments and public health officials grapple with finding solutions to the HIV epidemic all over the world, human rights activists have been advocating for 'a human rights-based approach to HIV'.[69] 'Respect for human rights in the context of HIV leads to markedly

67. Fick, N., London, L. & Coomans, F. 2011. Toolkit on the Right to Health. Cape Town: Learning Network.

68. See World Health Organisation's Office of the United Nations High Commissioner for Human Rights ' Right to Health Fact Sheet No. 31 accessed from https://www.ohchr.org/documents/publications/factsheet31.pdf on 13 October 2020. Also see Sub-regional policy and protocols: (1) The SADC Protocol on Health The Health Policy Framework accessed from https://www.sadc.int/themes/health/ on 13 October 2020.

69. Open Society Institute and Equitas at pp. 2-2–-5. See also OHCHR.

better prevention and treatment. Respect for the dignity and privacy of individuals can facilitate more sensitive and humane care. Stigmatization and discrimination has a negative impact on both medical and public health efforts to help combat TB and HIV related illnesses.[70] Prevention of human rights abuses and access to justice are crucial to mitigating stigma and discrimination that continue to be a challenge in the management of HIV and TB in South Africa.

The Constitution, together international bodies, have helped South Africa to establish an enabling legal environment that protects and promotes human rights and gender equality, thus encouraging a rights-based approach to health for all, including the key and vulnerable populations.

Protective laws, policies and practices in support of non-discrimination, equality and freedom are enshrined in our legal system and legal remedies are readily available for violations against the key and vulnerable, these legal remedies shall be explained in greater detail, in the chapters dealing specifically with the key and vulnerable populations.

70. JL Holmes 'A human rights-based approach to HIV health care' HIV Clinician 24(3) (2012): 1 at p. 1, quoting the first director of the Global Programme on AIDS at the World Health Organisation, Jonathan M.

CHAPTER 3

HIV TESTING,TB SCREENING AND THE RIGHT TO PRIVACY AND CONFIDENTIALITY

1. HIV Testing

1.1. Principles Relating to HIV Testing and Counselling

Voluntary Human Immunodeficiency Virus (HIV) testing and counselling has been identified globally as a key strategy to achieving a significant reduction in the spread of HIV. Through voluntary testing and counselling, countries aim to empower individuals with knowledge about their HIV status, and through this knowledge, hope to engender a culture of responsible sexual behaviour generally and to encourage early access to treatment in particular.[1]

A parallel objective of 'own-status awareness' is a better understanding of issues related to HIV and TB, including the undue discrimination, stigma and scourge associated with HIV and Tuberculosis (TB). Another objective of this is the positive contribution that each individual can make in the fight against the epidemic through knowledge, healthy lifestyle decisions and general respect for others.[2]

With this focus on 'own-status awareness' comes an increased need to foster general communal trust regarding the protection of individuals' rights relating to their HIV or TB status. Specifically, it is important that all persons (whether in their private or professional capacity) understand the protection that the law affords them, the information regarding their HIV status and related test results, together with the legal remedies available when their legal rights are unlawfully infringed.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organisation (WHO) Policy Statement on HIV Testing advocates for the '3 Cs' to be the underpinning principles for the conduct of HIV and TB testing.[3] Such testing must be:

- **Confidential**;
- Accompanied by **Counselling**; and
- Conducted with informed **Consent** only.

A more recent joint statement issued by the WHO and UNAIDS[4] advocates five key component ('5 Cs') that must be respected and adhered to by all HIV and TB testing and counselling services:

- Consent;
- Confidentiality;
- Counselling;
- Correct test results; and
- Connection/linkage to prevention, care and treatment.

1.2. Informed Consent in HIV Testing

Informed consent[5] can be described as consent based on:

- pre-test counselling covering the purpose of the laboratory test, the advantages or disadvantages of testing for the patient in question, the influence the test will have on the patient's treatment, the reason why the healthcare professional (HCP) wants the information and how the patient's medical protocol will or may be altered by the information.
- communications with an HCP conducted in a language easily understood by the patient[6]
- the patient's clear and proper understanding of the information provided.[7]

1. Commonwealth Regional Health Community Secretariat. 2002. HIV/AIDS voluntary counselling and testing: review of policies, programmes and guidelines in east, central and southern Africa. Arusha, Tanzania. Arusha: CRHCS accessed from https://www.who.int/hiv/topics/vct/toolkit/components/policy/review_of_policies_programmes_and_guidelines.pdf on 13 October 2020.
2. Avert: HIV & Aids in South Africa' accessed from https://www.avert.org/professionals/hiv-around-world/sub-saharan-africa/south-africa on 19 June 2020.
3. See 'UNAIDS/WHO policy statement on HIV testing', June 2004, accessed from at http://data.unaids.org/una-docs/hivtestingpolicy_en.pdf; Guidelines for Good Practice in the Health Care Professions, Booklet 11; 'Statement on HIV testing and counselling: WHO, UNAIDS re-affirm opposition to mandatory HIV testing', 28 November 2012, available at http://www.who.int/hiv/events/2012/world_aids_day/hiv_testing_counselling/en.
4. Ibid.
5. See Guidelines for Good Practice in the Health Care Professions, Booklet 11 at para. 6.
6. See also the Department of Health's HIV Counselling and Testing (HCT) Policy Guidelines at s 6.2, available at http://sanac.org.za/resources/cat_view/1-resources.
7 Posters used to inform patients about HIV testing must be supplemented by oral pre-testing counselling by the HCP.

1.2.1. Pre-test and Post-test Counselling Cover some of the Following Issues:[8]

1.2.1.1. Pre-test Counselling

- The reasons a patient decided to come for counselling
- Defining counselling and its role
- The patients personal history
- Any health problems
- The risk of being HIV infected
- Knowledge about HIV/AIDS
- Provide Information about HIV/AIDS, including the test procedure and information about what People Living with HIV (PLHIV) can do to make sure that they stay as healthy as possible for as long as possible
- What alternatives there are for solving problems associated with being HIV positive
- Any issues the patient want to discuss before the test.
- What impact you think a positive, indeterminate or negative result or negative result would have on the patient's life and how the patient think they would react to receiving them.
- The advantages and disadvantages of having the test
- The patients support system including the person who the patient is likely to disclose to if tested HIV positive

1.2.1.2. Post-test Counselling

- Counsellor will provide test result face-to-face. HIV test results are never shared telephonically.
- Let the patient express their feelings about being HIV positive or negative
- Discuss preventative measure if test is HIV negative
- Provide information on other resources available if the patient test positive
- Revisit issues raised during the pre-test counselling session, including any plans the patient has made
- Discuss any immediate problems and help the patient decide on a plan of actions
- Answer any questions that the patient may have and provide useful information
- Discuss positive living with HIV

The communications with a healthcare professional must be conducted in a language easily understood by the patient and the patient must have a clear and proper understanding of the information provided'.[9]

Section 12 of the South African Constitution provides that, *"Everyone has the right to freedom and security of the person"* which includes, the right to not to be subjected to medical or scientific experiments without informed consent.[10]

The rationale of these sections are found in Chapter 2: Section 6, 7 and 8 of the National Health Act (NHA),[11] which provides for the type of information that must be discussed with the patient. No health service may be provided to the patient unless informed consent is obtained and that the patient has the right to participate in any decision regarding his or her body, respectively. Section 7 of the NHA specifically states that a healthcare professional must take all reasonable steps to obtain a patient's informed consent.

Consent should be given freely and voluntarily – it may not be obtained through fear, coercion, threats, fraud or other undue influence.[12] The patient giving consent must also have the capacity to do so.[13] All persons have the right to refuse testing but no person may be refused treatment on the basis of his or her refusal.[14]

8. HIV Testing and Counseling accessed from http://www.kznhealth.gov.za/art.htm on 19 June 2020.
9. G Kekesi 'HIV testing, confidentiality and informed consent' in A Vukeya Motsepe 'HIV and the Law in South Africa: A Practitioner's Guide (2016) at 7.
10. Section 12 of The Constitution of the Republic of South Africa of 1996.
11. National Health Act 61 of 2003, s 7 sub-s (1) Subject to section 8, a health service may not be provided to a user without the user's informed consent, unless-
    (a) The user is unable to give informed consent and such consent is given by a 25 person-
        (i) mandated by the user in writing to grant consent on his or her behalf or;
        (ii) authorised to give such consent in terms of any law or court order'
12. See also the Department of Health's HIV Counselling and Testing (HCT) Policy Guidelines at s 6.2, available at http://sanac.org.za/resources/cat_view/1-resources. at s 6.2.
13. Ibid. at para. 6.2.2.
14 Guidelines for Good Practice in the Health Care Professions, Booklet 11 at para 4.2 read with para 8.1.

Therefore, before Healthcare Professionals can administer an HIV and TB test, they must ensure that the patient has given his or her informed consent.[15]

The doctrine of informed consent was introduced in South Africa in 1994 in *Castell v de Greef*[16] where a patient sued her plastic surgeon after her double mastectomy. The Supreme Court of Appeal 'adopted a subjective, patient-centered test for informed consent'.[17] Notably, the 'Court found that informed consent requires a patient to:

- Know the nature and extent of the risk or harm that accompanies a procedure;
- Understand the nature and extent of the risk or harm;
- Agree in detail to the procedure under discussion; and
- Agree in detail to all parts of the risk or possible harm'.

The principles established in this case with regards to informed consent were important as they were in line with the rights of self-determination and individual autonomy afforded to everyone in South Africa. The court held that a healthcare provider must share all information and risk about a procedure that a patient would need to know.[18]

1.3. HIV Testing for Children

The Children's Act allows for children over the age of 12 to consent independently to HIV testing if they have the necessary capacity. However, it is imperative that the HIV test is always in the best interests of the child, along with the requisite consent given otherwise such testing may not take place.[19]

See detailed discussion in Sub – Chapter 4.2.

1.4. HIV Testing in Employment

The Employment Equity Act[20] does not permit the testing of employees for the purpose of ascertaining their HIV status unless the Labour Court decides that such testing is *'justifiable in terms of section 50 (4) of the Act'*. *'However, anonymous or voluntary HIV testing is permitted without the need for an order from the Labour Court'*.[21]

See detailed discussion in Chapter 6.

2. TB Screening

2.1. Principles Relating to Active TB Screening

Diagnosis of patients who have contracted TB that are delayed or missed in addition to a lack of access to high quality care 'especially where population density is high and living conditions are poor', can lead to a longer chance of infectiousness, transmission and thus, a higher risk of death and suffering as a result of the disease. 'A person who is actively ill with the disease is able to transmit the disease, because bacteria can be expelled from the body during sneezing, coughing, or spitting.[22] The bacterium is vulnerable to sunlight and fresh air, but if it is expelled in a closed environment, for example, by someone coughing in a poorly ventilated room, it can drift around for hours.[23] Hence, the need arises to increase high-quality diagnosis of TB in several ways including screening which has thus far, 'greatly contributed to the declining rate of the global prevalence of TB'.[24]

15. Ibid. at para. 4.3.
16. 1994 (4) All SA 63 (C).
17. South African Litigation Centre: "Protecting Rights: Litigating Cases of HIV Testing and Confidentiality of Status" 2012 at 56.
18. Op cit note 16 at para 80.
19. Children's Act 55 of 1988, s129 sub-s (2) A child may consent to his or her own medical treatment or the medical treatment of his or her child if-
    (a) The child is over 12 years; and
    (b) The child is of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the treatment.
20. Employment Equity Act 55 of 1998.
21. Op cit note 9.
22 Department of Minerals and Energy: "Guidance note for occupational medical practitioners, tuberculosis control programmes" 2003 at 8.
23 Ibid.
24. World Health Organisation "Principles and Recommendations for the Systematic screening for active tuberculosis" 2013 at 26.

According to the principles and recommendations of the WHO, 'Systematic screening for active TB is defined as the systematic identification of people with suspected active TB, in a predetermined target group, using tests, examinations or other procedures that can be applied rapidly'.[25] These tests must be able to successfully determine who is most likely to have active TB. The status of a person must be established by several tests and assessments to ensure high accuracy in the diagnosis of TB patients.[26]

The key principles of systematic TB screening include, 'high-quality TB diagnosis, treatment, care, management and support for patients' prior to screening as well as a means to increase support.[27] Once the results of the screening have been disclosed, there is a greater need for TB treatment and support. Similar to HIV testing, TB screening must adhere to ethical standards for screening and to observe human rights which aim is to minimize 'the risk of discomfort, pain, stigma and discrimination.[28]

When screening children under the age of 10 and children living with HIV or thin contact with someone who has TB, they have to undergo symptom-based screening, and if any of the relevant symptoms are found, they have to be investigated for TB.[29] In addition, chest radiography may be added to the initial screening.[30] Thus, the primary objective of systematic screening is to detect TB early in order to reduce risk of transmission. The secondary objective is to rule out the presence of active disease in persons while also identifying people who are at a high risk of developing the disease in future.[31]

2.2. Informed Consent in TB Screening

Like HIV, early detection of TB is essential to further improve health outcomes for PWTB, and to reduce TB transmission more effectively. The WHO introduced systematic screening in high risk groups as a possible complement to efforts to improve the patient-initiated pathway to TB diagnosis,[32] and endorsed the use of a new DNA-based test for TB. The Gene Xpert TB Screening machine is expected to revolutionise the care of TB, especially multidrug-resistant (MDR)-TB by providing accurate diagnoses in less than two hours. The question arises as to whether informed consent to TB testing and screening by health professional is required.[33]

In the South African Constitution, informed consent is grounded in the principle of bodily integrity and access to information.[34] Therefore, although it has been argued that 'TB is different from situations such as routine blood analysis, where testing can legitimately be performed without even notifying the patient, … 'individuals should be notified that the test will be performed and given basic information.'[35] The WHO has also emphasised that 'TB screening should follow established ethical principles for screening for infectious diseases, observe human rights, and be designed to minimize the risk of discomfort, pain, stigma and discrimination.'[36]

25. Ibid at 7.
26. Ibid at 7.
27. Ibid at 9.
28. Ibid at 9.
29. Ibid at 15.
30. Ibid at 15.
31. Ibid at 29
32. World Health Organisation "Systematic screening for active tuberculosis Principles and recommendations" accessed from https://apps.who.int/iris/bitstream/handle/10665/84971/9789241548601_eng.pdf;jsessionid=17A848C7AFB4001FF0FE29E9F8B6462B?sequence=1 on 25 April 2020.
33. Carl et al "The role of informed consent in tuberculosis testing and screening European Respiratory Journal 2012 39: 1057-1059; volume 39 at 1057.
34. A Nienaber and K N Bailey 'The right to physical integrity and informed refusal: Just how far does a patient's right to refuse medical treatment go?' South African Journal of Bioethics and Law Volume 9 No. 2 (2016).
35. Op cit note 25.
36. Ibid.

2.3. TB Screening in Employment

Section 55 (4) (b) of the Public Service Act[37] which provides for the administration of the public service sector TB screening, states that the head of department will take all steps to ensure and accommodate TB screening and support of adequate treatment for all employees. This mandate is also provided for in the South African Police Service Act 68 of 1995[38] which requires the national commissioner to ensure and accommodate TB screening and support.[39] The Department of Mineral Resources and Energy has provided a guidance note for occupational medical practitioners for TB control programmes, it states that where risk assessment indicates that workers require annual screening in the form of chest X-rays, it should be done by a competent professional.[40] Furthermore, there should be concern about miners who share a room with someone diagnosed with TB.

2.4. TB Screening in Prison

In *Lee v Minister of Correctional Services*,[41] Lee was imprisoned for four and a half years during which time he was diagnosed with TB. When the prisoner was released, he instituted action against the state arguing that the states' employees had caused him to become infected with TB, whether negligently or intentionally. Lee argued that as prisoners, they were kept in close proximity to one another and also complained of inadequate nutrition and treatment. 'The court found that the conduct of the state and its officials failing to take steps to protect against the spread of TB in prison was unlawful and thus, the state was liable in delict to the plaintiff'.[42] In addition to contravening various sections of the Correctional Services Act 8 of 1959, the defendant also infringed the prisoner's right to physical integrity.[43]

3. The Right to Privacy and Confidentiality

3.1. General Legal Principles Relating to the Right to Privacy

The HIV or AIDS status of an individual is generally considered a private fact to which the right to privacy attaches. A private fact is considered by South African courts as a fact 'the disclosure of which will cause mental distress and injury to anyone possessed of ordinary feelings and intelligence in the same circumstances and in respect of which there is a will to keep [the fact] private'.[44] Privacy, in turn, is said to encompass 'the right of a person to live his or her life as he or she pleases'.[45] The following is also noteworthy in the context of private facts: 'Private and confidential medical information contains highly sensitive and personal information about individuals. The personal and intimate nature of an individual's health information, unlike other forms of documentation, reflects delicate decisions and choices relating to issues pertaining to bodily and psychological integrity and personal autonomy.'[46] Furthermore, 'the disclosure of an individual's HIV status, particularly within the South African context, deserves protection against indiscriminate disclosure due to the nature and negative social context the condition has, as well as the potential intolerance and discrimination that result from its disclosure'.[47]

Section 14 of the Constitution provides that every individual in South Africa enjoys a right to privacy. This includes the right not to have the privacy of one's communications infringed.[48]

37. Act 103 of 1994.

38. Section 28 (4).

39. Act 68 of 1995,s38 *(4)*.

40 Department of Mineral Resources and Energy: Republic of South Africa ' Guidance Note for Occupational Medical Practitioners TB Control Programmes' access from on 11 January 2021 https://www.dmr.gov.za/Portals/0/Resource%20Center/Guidelines%20for%20the%20Mandatory%20Codes%20of%20Practice/Guidance%20Note_Tuberculosis%20Control%20Programme.pdf?ver=2018-03-13-013131-310

41. Lee v Minister of correctional Services 2012 (3) SA 617 (SCA).

42. Op cit note 16.

43. Correctional Services Act 111 of 1998.

44. *NM and others v Smith and others* (*Freedom of Expression Institute* as amicus curiae) 2007 (5) SA 250 (CC) at para. 34.

45. Ibid. at para. 33.

46. Ibid. at para. 40.

47. Ibid. at para. 42.

48. Section 14(d) of the Constitution.

The Protection of Personal Information Act 4 of 2013 (PPI),[49] has strengthened protection and enforcement of the right to privacy. The PPI Act provides for justifiable limitations aimed at balancing the right to privacy against other rights, particularly the right of access to personal information including medical information.[50]

It is apparent that South African law protects information on one's HIV or AIDS status as a right to privacy through common law, and legislation. These legal regimes may be used to pursue both civil and criminal actions against alleged violators of that right.

Under international law, which is applicable in South Africa, Article 17 of the International Covenant on Social and Political Rights provides that: 'No one shall be subjected to arbitrary or unlawful interference with his privacy, family home or correspondence, or to unlawful attacks on his honour and reputation; and everyone has the right to the protection of the law against such interference or attacks.'[51] In the South African context, the protection of the privacy of an individual's private medical information is crucial because of the negative social effects that could take place as a result of the disclosure, such as discrimination.[52]

A landmark case on the right to Privacy is *NM and Others v Smith and Others*[53] where the applicants, three HIV-positive women's names were published in a biography without their consent. As a result, they claimed their rights to privacy, dignity and psychological integrity had been infringed'.[54] The applicants first sought an interdict against the continued publication of the book and later withdrew the application. They requested the removal of their names from the book and the respondents declined to do so. The applicants sued the respondents for damages in the Johannesburg High Court. The High Court held that the disclosure of the applicants' names in the book was not unlawful because the respondents were not negligent in assuming that consent had been given to the University of Pretoria and did not act with the requisite intent to reveal private medical facts. The High Court held, however, that failure to stop the distribution of copies of the book after it had become apparent that consent had not been given, violated the applicants' right to privacy and ordered the publisher to pay them R15 000 each in damages. The applicants unsuccessfully appealed to the Supreme Court of Appeal. On Appeal at the Constitutional Court, the applicants argued that the High Court failed to give sufficient weight to the 'public perception of stigma, degradation and discrimination that goes with HIV/AIDS'. The decision of the High Court was set aside by the Constitutional Court. It held that the respondents were aware that the applicants had not given their express consent but had gone ahead and published their names, violating their privacy and dignity rights. The use of pseudonyms instead of the applicants' real names would not have rendered the book any less authentic and nowhere could it be shown that the public interest demanded otherwise.

The right to privacy in respect of PLHV and PWTB, warrants constitutional protection due to the nature and negative social context surrounding the illness as well as the potential intolerance and discrimination that result from its disclosure.[55] PLHIV and PWTB have the right to confidentiality and privacy concerning their health status. Information regarding a person's HIV and TB status may not be disclosed without their consent or, in the event of his or her death, the consent of their next of kin, except when required by law.

In light of the above and in South African law, a person's HIV or AIDS status is a private (medical) fact falling under the right to privacy.

In addition, the right to privacy is a common-law personality right aimed at protecting a person's dignity. It embodies confidentiality which, unless otherwise established as a duty by way of statute, generally exists only in special

49. At the time of writing, parts of the Act had come into effect – mainly sections relating to the establishment of the Information Regulator and related operational matters – but not the substantive parts of the Act.

50. See s 1 of the PPI Act s.v. 'personal information'.

51. Adopted by the General Assembly of the United Nations in December 1966.

52 Above at n1 para (42).

53 *2007* (5) SA 250 (CC).

54. Above at n1 para (1).

55. *NM and Others v Smith and Others* 2007 (5) SA 250 (CC) at para 42.

relationships such as those between an attorney and his or her client or a doctor and his or her patient. In addition, the right to privacy is a fundamental right enshrined in the Bill of Rights of the South African Constitution.[56] In the context of HIV and AIDS, it is important that legal practitioners, on behalf their clients take into account *inter alia* the following:

- The constitutional right enjoyed by everyone 'to bodily and psychological integrity, which includes the right not to be subjected to medical or scientific experiments without informed consent';[57]
- Provisions of the NHA; and[58]
- Ethical rules or guidelines regulating healthcare providers.

The *NM and others v Smith and others*,[59] case highlighted that the right to privacy results in the violation of human dignity. Given the stigma that is attached to HIV, disclosure of a person's HIV status may lead to that person being ostracised by family or by the community.

3.2. General Legal Principles Relating to the Right to Confidentiality

The NHA declares as confidential all information concerning what it describes as a 'user', including information relating to a user's health status or treatment ('medical information') in a 'health establishment'.[60] The Act defines 'user' as a person receiving treatment in a health establishment or using a health service[61] (for the purposes of this chapter, a user is a patient). 'Health establishments' include hospitals and other private or public institutions where healthcare services and medical treatment are provided.[62] It is unclear whether all types of testing centres are included in the meaning of health establishment. However, all testing centres are nonetheless bound by the Constitution and by common-law principles of the right to privacy.

The test results of HIV-positive patients constitute medical information and as such must be treated with the highest standard of confidentiality.[63] The Health Professions Council of South Africa's Guidelines for Good Practice in the Healthcare Professions (HPCSAA guidelines) provide that, with regard to HIV, confidentiality extends to reporting of HIV test results by a laboratory.[64] This implies that, for the purposes of HPCSA guidelines, laboratories and other testing centres may be treated as 'health establishments' as contemplated in the NHA.

The right to privacy (and the concomitant duty of confidentiality) binds individuals not only in their private capacity but also in their capacity as professionals in fields such as medicine and the media. In *Jansen van Vuuren and another NNO v Kruger*,[65] a doctor discussed the HIV status of his patient with colleagues during a game of golf. The news of the patient's medical condition spread throughout the small community. The patient lodged a civil claim for compensation from his doctor for violating his right to confidentiality. The court confirmed that 'The duty of a physician to respect the confidentiality of his patient is not merely ethical but is also a legal duty recognised by the common law'.[66]

56. See Chap. 2 of the Constitution of the Republic of South Africa, 1996.
57. S 12 of the Constitution of the Republic of South Africa.
58. Act 61 of 2003. This Act was amended by the National Health Amendment Act 12 of 2013 but not the sections referred to in this chapter.
59. 2007 (5) SA 250 (CC).
60. S 14(1).
61. S 1 s.v. 'user'.
62. See s 1 s.v. 'health establishment', 'hospital' and 'health services'.
63. Guidelines for Good Practice in the Health Care Professions, Booklet 11: 'Ethical guidelines for good practice with regard to HIV' (May 2008) at para. 4.3, available at http://www.hpcsa.co.za/Conduct/Ethics.
64. Ibid. paras 5.2 and 5.5.
65. 1993 (4) SA 842 (A).
66. Ibid. at para 850

4. Legal and Ethical Duty of Confidentiality: Healthcare Providers

According to the Ethical Rules of Conduct for Practitioners[67] that were developed to give effect to the Health Professionals Act 1974,[68] a healthcare practitioner should honour a patient's autonomy by respecting their right to self-determination and making informed choices regarding their health.[69] Rule 13 of the Act provides that a healthcare practitioner is broadly permitted to divulge information regarding a patient only:

- In terms of a statutory provision (such as those in the NHA);
- At the instruction of a court order;
- In the public interest or;
- With the express consent of the patient.

In the case of minors, the written consent of a parent or guardian is required. In the case of a deceased patient, the written consent of the next of kin or executor of the deceased estate is also required.[70] The Sexual Offences and Related Matters Act 24 of 2015 also emphasizes the confidentiality of the HIV and TB status of prisoners stating that "The results of the HIV and TB tests performed on an alleged offender in terms of this Chapter may, subject to subsection (2) be communicated only to:

- A victim of interested persons referred to in s 30;
- Alleged offender; or
- An investigating officer'.[71]

Section 1.3 of the Pharmacy Act[72] provides that a pharmacist must respect the confidentiality of information acquired in the course of professional practice relating to a patient and may not disclose such information except under certain prescribed circumstances.

5. Disclosure to Partners by Healthcare Practitioners

It is important to note that the National Policy equalizes the concern for privacy with the concern for the general public welfare. It does this by highlighting the responsibility that is assigned to a person with HIV and TB to protect other people from infection and society's right to that protection. 'The guidelines recommend that healthcare practitioners do the following to protect sexual partners of HIV- positive patients:

- Counsel the patient on the need to inform third parties at risk;
- Attempt to obtain the patient's informed consent and offer to assist in the process of disclosure;
- Point to the legal and other risk associated with negligent sexual behavior; and
- If an identified third party is clearly at risk, inform the patient about a planned disclosure'.[73]

6. Conflict of Rights: Right to Privacy and the Public Interest

In terms of South African case law an overwhelming public interest may justify the publication of medical information including a person's HIV/AIDS status.[74] Even if the initial disclosure of medical information was unlawful because, for instance, it contravened the NHA and potentially constitutes a crime in terms of that Act, it may not be possible to prevent further disclosure if such disclosure would be in the public interest.[75] In this regard, public interest may be regarded as an additional defence for disclosing private medical facts. In the case of *NM v Smith*, Madala J stated that the

67 GN R717 in Government Gazette 29079 of 4 August 2006.

68. Act 56 of 1974.

69. The Healthcare Professionals Council of South Africa "Guidelines for Good Practice in the Healthcare Professions" Booklet 1 2016 Pretoria. Available at http://www.hpcsa.co.za.

70 Rule 13 (2)(b) and (c) of Ethical Rules of Conduct for Practitioners.

71. Sexual Offences and Related Matters Amendment Act 24 of 2015, s37.

72. No 53 of 1974, s1.3.

73. Op cit note 13 at 229.

74. *NM and others v Smith and others (Freedom of Expression Institute* as amicus curiae) (fn. 2 above) at paras 45 and 209.

75. *Tshabalala-Msimang and another v Makhanya and others* (fn. 17 above) at paras 32–54.

issue before the court involved 'a nuanced and sensitive approach to balancing the interests of the media, in advocating freedom of expression, privacy and dignity of the applicants irrespective of whether it is based on the constitutional law or common law'.[76] The court noted that in understanding the scope of privacy, it is important to recognize that, at times, the right to privacy might suggest that certain facts should not be published while at the same time the right to freedom of expression might suggest that those same facts should be allowed to be published. Freedom of expression is enshrined in s16 of South Africa's Constitution,[77] and it enables the free and open exchange of ideas which is important for a democratic society.[78] Furthermore, freedom of expression encourages the development of individuals as they are able to formulate and develop more individual and critical thoughts and opinions on social issues, which serves the public interest.

Codes of media ethics will often be useful in considering the question of how privacy and freedom of expression should be balanced in our law. The codes of conduct on the record emphasize the importance of privacy, but also recognize the possibility of overriding privacy in the public interest or where there is informed consent.' However, in this case neither of these defenses was used as the respondents did not assert that the publication of the names of the applicants was in the public interest. The court concluded that the rights of the applicants were infringed and that there was no evidence that this was done in the public interest'.[79] It also continued to hold that people value their right to privacy in respect of their medical information because of the potential harmful effects that could result from the disclosure of such information.[80]

In another case, *Tshabalala-Msimang and another v Makhanya and others*, where a person acquires knowledge of private facts through a wrongful act of intrusion, any disclosure of such facts by such a person or by any person, in principle, constitutes an infringement of the right to privacy. the first applicant argued that an article contained allegations 'which were defamatory and invasive to her right to privacy and dignity'.[81] The Sunday Times had access and possession of the applicant's medical records even though the applicant had never authorized publication of such documents. Thus, the applicant's contention was that the Sunday Times was contravening s17 of the National Health Act, 61 of 2003[82] 'and was therefore unlawful'.

7. Legal Remedies to Individuals whose Privacy has been Unlawfully Infringed

7.1. Judicial Remedies

As the supreme law of the country, the South African Constitution requires all conduct and law to be interpreted in a manner that is consistent with its provisions. It is therefore necessary for the law of delict to be interpreted in such a manner. The right to privacy is one of the fundamental rights entrenched in the Constitution,[83] standing alongside other rights such as the right to dignity,[84] the right to freedom of expression[85] and the right to freedom of belief and opinion.[86] Like other rights in the Bill of Rights, the right to privacy can be limited by the law of general application 'to the extent that the limitation

76. Ibid at para 31.

77. The Constitution of the Republic of South Africa 1996.

78. Above at n1 para *(154).*

79. Above at n1 para *(54).*

80. Above at n1 para *(41).*

81. *Mtsimang and Another v Makhanya and Others* 2008 (6) SA 102 (W).

82. Section 17 sub-s (1) of National Health Act 61 of 2003 – 'The person in charge of a health establishment in possession of a health user's record must set up control measures to prevent unauthorised access to those records and to the storage facility in which, or system by which, records are kept'.

83. 1S No 108 of 1996

84. S 10 of the Constitution of the Republic of South Africa.

85. S 16.

86. S 15.

is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom'[87] and is therefore not absolute. It may even conflict with other fundamental rights in which case it will have to be weighed against those other rights.

7.1.1. Civil Claim

The *actio iniuriarum* arises from delicts that cause injury to personality *(iniuria)*. It is aimed at *solatium* or satisfaction or sentimental damages for wrongful and intentional injury to personality. Invasion of privacy is a form of *iniuria*. As is the case with other delictual claims, the *actio iniuriarum* requires the presence of the following five elements:

- Conduct;
- Wrongfulness;
- Fault (specifically, intention),
- Harm; and
- Causation.

Any conduct that is alleged must have been performed voluntarily before an enquiry into its wrongfulness can be undertaken'.[88]

In the case of *Jansen van Vuuren and another NNO v Kruger* the disclosure of private facts was considered an invasion of privacy.[89] In the case of *NM v Smith*, 'private facts have been defined as those matters that the disclosure of which will cause mental distress and injury to anyone possessed of ordinary feelings and intelligence in the same circumstances and in respect of which there is a will to keep them private'.[90] This case also proved to be informative because the identities of three women living with HIV were published in a biography. The court ruled in favor of the applicants stating their rights to privacy was infringed.[91]

Wrongfulness is a key element in founding liability for the invasion of another's privacy.[92] It involves a question of whether a legal right has been infringed or a legal duty has been breached. In the *Jansen* case the court had to look at whether the disclosure of the applicant's HIV status was justified, making sure to take into consideration the social context surrounding HIV, the stigma as well as the ethical duty placed on healthcare professionals. The court found that the patient had the right to expect confidentiality from their healthcare practitioner and thus there was unjustified breach of an ethical and legal duty on the part of the healthcare practitioner.[93] This was also found to be the case in *NM v Smith*.

For the purposes of the *actio iniuriarum* the type of fault required is intention'.[94] The courts found in the two cases mentioned above that HIV infected persons require a special protection of confidentiality in light of the harmful consequences that public disclosure of the applicants HIV and status can produce. Accordingly, the courts found that the respondents had been aware of the fact that the applicants had not given their consent to have their HIV and AIDS status disclosed and as such were held liable.[95]

'The injury sought to be compensated through the *actio iniuriarum* is injury to personality, specifically invasion of privacy. The type of compensation afforded to victims is non-patrimonial in nature and recognizes that there has been 'an impairment or disturbance of interests of personality which causes a reduction in their quality or utility'. These interests are compensated through 'satisfaction' which broadly relates to 'retribution for the wrong suffered by the plaintiff' and satisfaction of the plaintiff's or community's 'sense of justice'.

In *Jansen van Vuuren and another NNO v Kruger* the harm alleged was the invasion of privacy whereas in *NM and others v Smith and others* the harm alleged was the violation of the rights to privacy, dignity and psychological integrity'.[96] When the court is trying to

87. Ibid at section 36(1).

88. Op cit note 9 at 22.

89. *Jansen van Vuuren* and another NNO v Kruger 1993 (4) SA 842 (A) at 40.

90. Ibid at para 34.

91. Ibid at para 54.

92. Op cit note 9 at 22.

93. Ibid

94. Ibid at 23.

95. Ibid.

96. Ibid at 27.

quantify the damages that the victim has suffered and the remedy that will be awarded as a result, it will consider the 'nature and extent of violation, the social standing of the parties, nature and extent of the disclosure and any other aggravating factors which may be relevant'.[97]

Another case which can prove instructive when looking at the legal remedies available to applicants whose rights to privacy have been invaded is the case of *Msimang and another v Makhanya and Others*.[98] In this case an applicant contended that the Sunday Times had published details about her stay at a medical health facility and were in possession of her hospital medical records and consequently, had violated her right to privacy and dignity. The court ruled in favor of the applicant stating that the National Health Act as well as the Constitution entrenched her rights to privacy and dignity and as such the respondent was ordered to satisfy the relief sought.

7.2. Non Judicial Remedies

7.2.1. Complaints Against a Health Professional or Health Establishment

Section 18 of the NHA[99] provides for persons who would like to lay a complaint against a health professional or healthcare establishment due to the way they were treated. Every patient who is aggrieved has the right to lay a complaint and the right to have that complaint investigated. It also states that this procedure must be made visible at all public health establishments in a place where all persons can see it.

7.2.2. Complaints to the Health Professionals Council of South Africa

The Health Professionals Council of South Africa (HPCSA) is a 'self-regulatory body which has an internal complaint mechanism whereby one can lodge a complaint when the guidelines have been violated by a registered healthcare practitioner'.[100] It is important to note that HPCSA guidelines are not binding but there is a Committee of Preliminary Enquiry which is responsible for investigating any violation which, if found to be true, could lead to the suspension of the healthcare professional or practitioner involved or the payment of a fine. To ensure that complaint mechanisms against healthcare practitioners are less biased in their favor, the Pretoria High Court in the case of *VRM v Health Professionals Council of South Africa* found that the Committee of Preliminary Enquiry of the HPCSA cannot decide on matters or complaints that raise disputes of fact. This is because of the influence the Committee is likely to have on outcomes regarding the accused healthcare practitioners.[101]

The HPCSA provides that the process of lodging a complaint is the following:

- Commence by lodging a complaint in writing addressed to the Registrar, either online or by completing a complaint form and emailing it to legalmed@hpcsa.co.za or by courier or hand delivery to 553 Madiba Street, Arcadia, Pretoria, 0001 or by post to PO Box 205, Pretoria, 001;[102]
- If your complaint is related to a hospital, 'Any person may lodge a complaint with the Office of Health Standards Compliance (OHSC) for breach of any norms or standards by both public and private health establishments';[103]
- If your complaint is related to a nurse, 'If you feel that a nurse acted negligently or unethically, individual nurses can be reported to the South African Nursing Council (SANC) to investigate the complaint';[104] and
- If your complaint is related to 'an alternative healthcare practitioner', 'If you feel that an alternative healthcare practitioner acted negligently or unethically, report to the Allied Health Professions Council of South Africa (AHPCSA)to investigate the complaint'.[105]

97. Ibid at 28.
98. Msimang and Another v Makhanya and Others 2008 (6) SA 102 (W).
99. No 61 0f 2003. Section 18, sub-s (1) Any person may lay a complaint about the manner in which he or she was treated at a health establishment and have the complaint investigated. (2) the relevant member of the Executive Council and every municipal member must establish a procedure for the laying of complaint within those areas of the national health system for which they are responsible.
100 Op cit at 13.
101. Op cit n11 at 229.
102. The Healthcare Professionals Council of South Africa: Legal and Regulatory Affairs. accessed from https://www.hpcsa.co.za/?contentId=452&actionName=Legal%20and%20Regulatory%20Affairs.on 19 June 2020
103. Ibid.
104. Ibid.
105. Ibid.

7.2.3. How to Lodge a Complaint to the HPCSA

The Procedural Regulations Pertaining to the Functioning of the Office of Health Standards Compliance and Handling of Complaints by the Ombud are regulations made by the Minister of Health which came into operation on November 2, 2016. According to the HPCSA, an ombud or ombudsman is a person appointed by the council to mediate in the case of minor transgressions referred to him or her by the Registrar for mediation.[106]

A complaint to the ombudman can be laid in the following ways:

- Orally (including by telephone) or in writing, by email or other electronic means;
- The Ombudsman must make sure to make record of the complaint and must confirm accuracy of complaint with the complainant;
- Ombudsman must provide the complainant with reasonable assistance where necessary and ensure reasonable access to the ombudman is present to users of the healthcare system and other concerned persons;[107]
- The Ombud must acknowledge receipt of the complaint within 48 hours of laying the complaint and may then invite submissions regarding the complaint;
- Thereafter, the complaint will be screened and the ombudsman will make a decision as to whether or not he or she will be investigating the complaint;
- The relevant health establishment must be notified about the investigation before or once it the investigation has commenced and the ombudman is required to give progress reports every two months to the health establishment and complainant; and
- The ombudman must complete the investigation in 6 months and must inform the complainant and the relevant healthcare establishment within 10 days of the results of the investigation.[108]

106. Ibid.

107. The Procedural Regulations Pertaining to the Functioning of the Office of Health Standards Compliance and Handling of Complaints by the Ombud, s33- How to lay a complaint.

108. The Procedural Regulations Pertaining to the Functioning of the Office of Health Standards Compliance and Handling of Complaints by the Ombud, s34-38.

CHAPTER 4

ACCESS TO HEALTHCARE FOR KEY AND VULNERABLE POPULATIONS

1. Introduction

This chapter is an introductory chapter to access to healthcare for key and vulnerable population aimed to educate legal practitioners and other interested parties about the relevant legislation, policies and landmark cases relating to access to healthcare for People living with HIV (PLHIV) and People with Tuberculosis (TB) in South Africa. Specific issues that directly affects the key and vulnerable population are discussed in detailed in sub-chapters 4.1 to 4.7.

South Africa continues to have one of the highest burdens of HIV globally. This is in addition to the challenge of the management of Tuberculosis (TB) and human immunodeficiency virus (HIV) co-morbidity. Although it is making good progress towards the United Nations Programme on AIDS and HIV 90 – 90 – 90 – 90 targets,[1] 'HIV and [TB] related stigma and discrimination are recognized as key barriers both to the delivery of quality services by health providers and to their utilization by community members and health providers themselves'.[2] Punitive laws, policies and practices against sex workers and people who use drugs (PWID), as well as socio-cultural norms that drive physical and sexual violence against key populations, particularly women and children, also negatively affect access to, uptake of and retention in services.[3] Access to sexual and reproductive healthcare services, including responses to sexual and gender-based violence affects how such services are organised and provided.[4]

Goal 5 of the South Africa's National Strategic Plan for HIV, TB and STIs 2017- 2022, seeks to address human rights and gender related barriers that increase risk and prevent people from accessing services, in particular women, youth, sex workers, people who use drugs, inmates, LGBTI persons and persons with disabilities through:

- Reducing stigma and discrimination amongst people living with HIV or those with TB;
- Facilitating access to justice and redress for people living with, and vulnerable to HIV and TB; and
- Promoting an environment that enables and protects human and legal rights and prevents stigma and discrimination.

2. The Right to Access Healthcare

The preamble to the WHO's constitution[5] defines health as 'a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity' and goes on to say that '[t]he enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition'. The right to 'the highest attainable standard of health' is also articulated in various international human rights instruments to which South Africa is party.[6] Notably, article 12(1) of the International Covenant on Economic,

1. The targets provides a set of global goals on AIDS and HIV which provides that by 2020, the 'goal is that "90% of people living with HIV will know their HIV status, 90% of those who know their HIV-positive status will be accessing treatment, and 90% of people on treatment will have suppressed viral loads. See Spotlight: In – depth, public interest health journalism accesses on: https://www.spotlightnsp.co.za/2019/08/05/graphs-that-tell-the-story-of-hiv-in-south-africas-provinces/.
2. L Nyblade, A Stangl, E Weiss and K Ashburn 'Combating HIV stigma in health care settings: What works?' *Journal of the International AIDS Society* 12 (2009): 15.
3. The Global Fund "Baseline Assessment – South Africa: Scaling up Programs to Reduce Human Rights and Related Barriers to HIV and TB Services" November 2018 at ix, last accessed from https://www.theglobalfund.org/media/8147/crg_humanrightsbaselineassessmentsouthafrica_report_en.pdf?u=637166000660000000 on 20 June 2020.
4. Ibid.
5. 14 UNTS 185, adopted by the International Health Conference held in New York, 19 June to 22 July 1946, and signed on 22 July 1946 by the representatives of 61 states. The constitution came into effect on 7 April 1948.
6. Art. 25 of the Universal Declaration of Human Rights provides that '[e]veryone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services'. Art. 12(1) of the International Covenant on Economic, Social and Cultural Rights provides that parties to the Covenant 'recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'; art. 12(2) states that the steps those parties must take to achieve the full realisation of this right include those necessary for '(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases; (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness'. Art. 16 of the African Charter on Human and Peoples' Rights provides that '1. Every individual shall have the right to enjoy the best attainable state of physical and mental health. 2. State Parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.' See also art. 24 of the Convention on the Rights of the Child and art. 12 of the Convention on the Elimination of All Forms of Discrimination against Women.

Social and Cultural Rights (ICESCR) requires member states to respect, protect and fulfil the right to health.

The right to access to healthcare not only entails access to medicines and health practitioners but also 'imposes obligations on states to ensure the availability, accessibility, acceptability and quality of healthcare services for all, particularly vulnerable and marginalised groups'.[7] The Committee on ICESCR further articulates this right by stating that the obligation to realise progressively the right of access to healthcare services requires state parties to adopt measures that are 'deliberate, concrete and targeted towards the full realization of the right'.[8] Simply put, states must ensure that people live in conditions that do not harm their health but promote and fulfil the right to health. Private parties are also expected to promote and respect this right.[9] South Africa has a progressive constitutional, legislative and policy framework that protects PLHIV and PWTB and is consistent with international law, yet very few South Africans know about the law and what they can do to assert their rights to access to healthcare.[10]

2.1. Constitutional and Legislative Framework of the Right to Healthcare

Section 27(1) and (2) of the South African Constitution[11] guarantees the right to have access to healthcare services (including reproductive healthcare) and requires the state to take 'reasonable legislative and other measures, within its available resources, to achieve the progressive realisation' of this right. In terms of section 27(3), no one may be refused access to emergency healthcare services. Section 28(1)(c) of the Constitution provides that every child has the right to basic healthcare services. Section 7(2) requires the state to 'respect, protect, promote and fulfil the rights in the Bill of Rights' including the rights set out in sections 27 and 28.

The following pieces of legislation advance the constitutional rights to healthcare:[12]

2.1.1. The National Health Act[13]

The National Health Act (NHA) provides the framework for a single national health system. This system comprises both public and private-sector entities concerned with the financing, provision or delivery of health services.[14] Section 1 of the NHA defines a health establishment as 'the whole or part of a public or private institution, facility, building or place, whether for profit or not, that is operated or designed to provide inpatient or outpatient treatment, diagnostic or therapeutic interventions, nursing, rehabilitative, palliative, convalescent, preventative or other health services'.

The NHA provides for a number of basic healthcare rights which include the right to emergency treatment in an environment that is not harmful to well-being. All provinces are required to align their provincial health legislation with the NHA.

Section 4 of the NHA requires that pregnant and lactating women, and children below the age of six, who are not

7. E Durojaye 'The approaches of the African Commission to the right to health under the African Charter' *Law, Democracy & Development* 17 (2013): 393 at pp. 395–396. See also M Pieterse *Can Rights Cure? The Impact of Human Rights Litigation on South Africa's Health System* (Pretoria: Pretoria University Law Press, 2014) at p. 128.
8. See the International Covenant on Economic, Social and Cultural Rights General Comment 14 at para. 30.
9. P Hunt, R Steward, J Bueno de Mesquita and L Oldring Neglected Diseases: A Human Rights Analysis, Special Topics in Social, Economic and Behavioural (SEB) Research Report Series No. 6 (Geneva: TDR/World Health Organisation) at p. 12.
10. M dos Santos, P Kruger, SE Mellors, G Wolvaardt and E van der Ryst 'An explanatory survey measuring stigma and discrimination experienced by people living with HIV/AIDS in South Africa: The People Living with HIV Stigma Index' BMC Public Heath 14:80 (2014), DOI 10.1186/1471-2458-14-80. at p. 7.
11. The Constitution of the Republic of South Africa, 1996.
12. Other legislation includes the Choice on Termination of Pregnancy Act 92 of 1996, which legalises abortion and allows for safe access to it in public and private health facilities, the Nursing Act 33 of 2005, which introduces mandatory community service for nurses, the Mental Health Care Act 17 of 2002, which provides for a process for the development and redesign of mental health services in recognition of the human rights of people with mental illnesses (see also the Mental Health Amendment Bill 2013), the Sterilisation Act 44 of 1998, which provides for the right to sterilisation, and the Health Professions Act 65 of 1974, as amended, which regulates the medical, dental and related professions. Another important development in health care policy and legislation is the Traditional Health Practitioners Act 22 of 2007, which regulates traditional health practices and traditional health practitioners.
13. Act 61 of 2003, as amended
14. See the mandate of the South African Office of Health Standards Compliance accessed from http://www.ohsc.org.za/index.php/who-we-are/mandate on 20 June 2020.

members or beneficiaries of medical aid schemes be provided with free health services; that 'all persons, except members of medical aid schemes and their dependants and persons receiving compensation for compensable occupational diseases' be provided with free primary healthcare services; and that women, subject to the Choice on Termination of Pregnancy Act,[15] be given access to free termination-of-pregnancy services.

Section 5 of the NHA provides that no 'healthcare provider, health worker or health establishment' can refuse to provide emergency medical treatment. Although this injunction also applies to private hospitals, in practice their 'pay now, operate later' policies could be said to contravene it.

2.1.2. Medicines and Related Substances Control Act[16]

The Medicines and Related Substances Control Act (Medicines Act) together with the general regulations issued under the Act,[17] govern the manufacture, distribution, sale and marketing of medicines under the responsibility of the Medicines Control Council (MCC).[18]

2.1.3. The Medical Schemes Act[19]

The Medical Schemes Act (MSA) regulates the private medical schemes industry.

2.2. Statutory Bodies that Regulate the Health Services Professions in South Africa

There are several statutory bodies that regulates the health services professions in South Africa. The most relevant of these are:

- The Allied Health Professions Council of South Africa was established in terms of the Allied Health Professions Act[20] to control all allied health professions which provide complementary and alternative healthcare including, for example, Chinese medicine, acupuncture and homeopathy.
- The Health Professions Council of South Africa (HPCSA), established in terms of the Health Professions Act,[21] guides and regulates the health profession in all aspects including registration, education and training, professional conduct and ethical behaviour of health practitioners. The Council also seeks to ensure the development of and foster compliance with healthcare standards.
- The Council for Medical Schemes (CMS), established in terms of the Medical Schemes Act, supervises medical schemes.
- The MCC was established in terms of the Medicines and Related Substances Control Act to regulate the performance of clinical trials and registration of medicines and medical devices. The MCC is responsible for ensuring that all clinical trials of unregistered medicines and of new indications of registered medicines comply with the necessary requirements for safety, quality and efficacy.[22] In this regard, the South African National Clinical Trials Register, under the auspices of the National Department of Health, provides the public with updated information on clinical trials being conducted on human participants in South Africa. The Register provides information such as the trial's purpose, who can participate, where the trial is being conducted and the contact details of people responsible for the trial. It also informs the public about their constitutional rights should anyone wish to participate in clinical trials.[23]

15. Act 92 of 1996
16. Act 101 of 1965
17. Issued under GN R510 in *Government Gazette* 24727 of 10 April 2003.
18. For further details about the Medicines Control Council, see http://www.mccza.com/about/default.asp.
19. Act 131 of 1998
20. Act 63 of 1982.
21. Act 56 of 1974.
22. Guidelines including, for example, guidelines on the registration of medicines can be accessed at http://www.mccza.com/Publications/Index/1.
23. See the South African National Clinical Trials Register's website at http://www.sanctr.gov.za.

- The Office of Health Standards and Compliance (OHSC) was established by the NHA[24] to protect and promote the health and safety of users of health services in South Africa. The OHSC is discussed in detail in paragraph 3.8 below.

All the above statutes and statutory bodies are aimed at ensuring that healthcare services are provided effectively and that healthcare professionals protect, respect, promote and fulfil the right to healthcare.

3. Landmark Cases which have given Meaning to the Constitutional and Legislative Framework Relating to Health in South Africa

The first important case dealing with section 27 is the matter between *Soobramoney v Minister of Health*,[25] Mr Soobramoney a dying diabetic man asked the courts to order a public hospital to provide him with dialysis treatment. Owing to limited resources, the hospital gave dialysis treatment only to those whose condition was curable or who, after chronic renal failure, were eligible for a kidney transplant. Mr Soobramoney did not meet any of these criteria. He contended that the government's decision had infringed his right to life in terms of section 11 of the Constitution and his right not to be refused emergency medical treatment in terms of section 27(3).

The Constitutional Court decided that Mr Soobramoney's condition was not one requiring emergency medical treatment within the meaning of section 27(3) and therefore a direct obligation did not rest on the state in this regard. The costs of providing Mr Soobramoney and everyone in a similar position to his with dialysis treatment were prohibitive for a provincial health system which was in debt. The court therefore decided to defer to the difficult policy decisions the executive had made and found that the executive was in fact complying with its obligation to provide progressive access to healthcare.

The court drew a distinction between the state's obligation to fulfil the right to medical treatment of terminal illnesses and its obligations in respect of other forms of medical care. It held that

> [i]n our Constitution the right to medical treatment does not have to be inferred from the nature of the State established by the Constitution or from the right to life which it guarantees. It is dealt with directly in section 27. If section 27(3) were to be construed in accordance with [Mr Soobramoney's] contention it would make it substantially more difficult for the State to fulfil its primary obligations under sections [sic] 27(1) and (2) to provide healthcare services to 'everyone' within its available resources. It would also have the consequence of prioritising the treatment of terminal illnesses over other forms of medical care and would reduce the resources available to the State for purposes such as preventative healthcare and medical treatment for persons suffering from illnesses or bodily infirmities which are not life threatening.[26]

Mr Soobramoney died shortly after the court's decision was handed down. The use of section 27 as a tool to force access to healthcare seemed to have died, too, in that the court seemed to have accepted the government's contention that resources were unavailable without enquiring whether the state was according 'due priority to the realisation of the right sought [i.e. the right to access healthcare services] by making available resources that ought to be available and utilising such resources effectively'.[27]

In another landmark case of *Minister of Health and others v Treatment Action Campaign and others (No. 2)*,[28] commonly known as the Nevirapine case, the government sought an order reversing the High Court decision that the government had acted unreasonably in refusing to make Nevirapine available in the public health sector when the attending doctor considered it medically indicated and in not setting out a time frame for a national programme for the prevention of mother-to-

24. National Health Amendment Act 12 of 2013.

25. 1998 (1) SA 765 (CC).

26. Ibid. at para. 19.

27. C Ngwena 'The historical development of the modern South African health-care system: From privilege to egalitarianism' De Jure 37(2) (2004): 290 at p. 309.

28. 2002 (5) 721; 2002 (10) BCLR 1033 (CC).

child transmission of HIV. The Constitutional Court had to decide whether the government was constitutionally obliged in terms of sections 27 and 28 of the Constitution to plan and implement such a programme throughout the country.

In a unanimous judgment, the court ordered the government to provide Nevirapine. It found that the constitutional obligations on the state required it to act reasonably to provide access to healthcare services and that the state's policy of not providing Nevirapine was contrary to the Constitution in that it was inflexible, unreasonable and denied mothers and children access to a potentially life-saving drug. The court also held that the government was constitutionally obliged 'to devise and implement within its available resources a comprehensive and co-ordinated programme to realise progressively the rights of pregnant women and their newborn children to have access to health services to combat mother-to-child transmission of HIV.'[29]

On 19 November 2003, the South African Cabinet approved the Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa which detailed, amongst other things, a public-sector ARV treatment programme for the provision of appropriate care in prisons.[30] Despite this, inmates infected with HIV and whose HIV infection met clinical guidelines for ARV treatment were not provided with ARVs. In *N v Government of Republic of South Africa* (No. 1),[31] the AIDS Law Project (now part of the organisation Section 27) brought an application to force prison authorities to provide ART to inmates of Westville prison who were being denied this life-saving medication. The court held that the denial of access to ARV violated prisoners' constitutional rights to medical treatment.

The rights of inmates living with HIV and those with TB are discussed in detail in sub – chapter 4.3.

Another seminal case is that of *Naude v Member of the Executive Council Department of Health Mpumalanga*[32] which dealt with the dismissal of a doctor because of his support for the provision of post-exposure prophylaxis to rape survivors at a public hospital in Mpumalanga which provision was contrary to policy at the time. The dismissal was found, hardly surprisingly, to be automatically unfair.

With regard to the right to emergency treatment, the Constitutional Court reconsidered section 27 in a case of *Oppelt v Head: Health, Department of Health Provincial Administration: Western Cape*[33] which a rugby player was paralysed when a scrum collapsed. He was rushed to a public hospital but, after some delays, moved to another hospital. Finally, he was taken to a third hospital where he received treatment some 13 hours after his injury. It was argued that had he received this treatment within 4 hours of his injury, he would not be paralysed. The court was split on the issue. The majority judgment decided that the:

> 'law requires hospitals to provide urgent and appropriate emergency medical treatment to a person in the position of the applicant. There is no doubt that the legal convictions of the community demand that hospitals and healthcare practitioners must provide proficient healthcare services to members of the public. These convictions also demand that those who fail to do so must incur liability.'[34]

In contrast to the Soobramoney case, the state did not claim that it did not have the resources to provide the treatment required.[35] After analysing the facts, the majority decided that the hospital protocol which led to the rugby player's not being sent promptly to the correct hospital for the correct treatment was unreasonable and constituted a 'constructive refusal' to provide the appropriate treatment and therefore found the state

29. Ibid. at para. 135.

30. See J Berger 'Implementing the Operational Plan in prisons' in 'AIDS Law Project: 18-Month Review: January 2006 to June 2007', accessed from http://www.tac.org.za/Documents/Court_Cases/Westville_Prisoners/Alp2007.pdf on 20 June 2020.

31. 2006 (6) SA 543 (D).

32. [2008] ZALC 158, (2009) 30 ILJ 910 (LC).

33. [2015] ZACC 33, (2016) (1) SA (CC).

34. Ibid. at para. 54.

35. Ibid. at para. 63. (This was so even though an urgent helicopter ride might have been required to transport the injured rugby player to the correct hospital for treatment.)

liable for the paralysis.[36] The minority decision took the view that the doctors, given the context in which they worked, the resources available to them and the state of knowledge about such injuries at the time, had acted reasonably and that it therefore would not have found the state liable.[37]

4. People Living with HIV and PWTB on Private Medical Aid Schemes

The South African Bill of Rights places constitutional obligations on both state and private institutions. In the public sector, the state acts as a provider of goods and services while in the private sector it must take reasonable steps to put in place a legal framework that facilitates access to healthcare. The healthcare sector in South Africa comprises both public and private healthcare. In 2019, one-fifth (22.6%) of South African households had at least one member who belonged to a medical aid scheme.[38]

The Medical Schemes Act and regulations[39] regulate medical aid schemes in South Africa. The MSA established the Council for Medical Schemes (CMS) which is aimed at protecting the interests of members of medical aid schemes. The functions of the Councils are consumer-oriented and include:[40]

- controlling and co-ordinating the functioning of medical schemes in a manner that is consistent with the National Health Policy
- investigating complaints and settling disputes related to the activities of the medical schemes as provided for in the MSA
- making rules that are consistent with the Constitution and provisions of the MSA
- collecting and disseminating private healthcare information
- making necessary recommendations to the Minister and performing any other function 'conferred' on it by the Minister or by the MSA.

The regulations under the MSA provide for obligatory Prescribed Minimum Benefits (PMBs) that every medical aid scheme in South Africa must offer its members including members living with HIV. PMBs include 270 medical conditions and 25 chronic illnesses which include HIV and TB. The CMS describes PMBs as 'a set of defined benefits to ensure that all medical scheme members have access to certain minimum health services, regardless of the benefit option they have selected'.[41]

PMBs were created to provide medical scheme members with continuous healthcare irrespective of whether their benefits for a year have run out. The provision of PMBs by schemes is obligatory regardless of where treatment is received.[42] As stated above, HIV/AIDS and TB are classified as PMB conditions; therefore, medical aid schemes

- cannot exclude PLHIV or PWTB from being members;
- must provide PLHIV and PWTB with the minimum benefits available to all members as defined in the MSA;
- cannot base their monthly premium on the fact that a person is HIV-positive or has a TB infection: they must base their premium on the type of cover the member wants and, on the dependants, covered; and

36. Ibid. at para. 68.

37. See para. 143, for example.

38. Businesstech ' Here is to how many South Africans have medical aid' 28 May 2019 accessed from https://businesstech.co.za/news/lifestyle/319696/heres-how-many-south-africans-have-medical-aid/ on 20 June 2020.

39. Issued under GN R1262 in Government Gazette 20556 of 20 October 1999 and amended by GN R1360 in *Government Gazette* 24007 of 4 November 2002.

40. See ss 7 and 8 of the MSA.

41. 'What are PMBs?', http://www.medicalschemes.com/medical_schemes_pmb/index.htm (accessed 15 February 2015).

42. D Pearmain 'Impact of changes to the Medical Schemes Act' in A Ntuli, N Crisp, E Clarke and P Barron (eds) *South African Health Review 2008* (Durban: Health Systems Trust, 2000) at p. 196.

- cannot impose a waiting period in respect of any treatment or diagnostic procedure covered by the PMBs.[43]

In relation to HIV and TB, medical scheme members are entitled to the following benefits:[44]

- Voluntary counselling and HIV testing;
- Co-trimoxacole as preventive therapy;
- Screening and preventive therapy for TB;
- Diagnosis and treatment of sexually transmitted infections;
- Pain management and palliative care;
- Treatment of opportunistic infections;
- Prevention of mother to child transmission of HIV;
- Post – exposure prophylaxis after occupational HIV exposure or sexual assault; and
- Medical management and medication including the provision of ARV therapy and on-going monitoring for medicine effectiveness and safety.

In order to benefit from PMBs, PLHIV and PWTB may need to provide medical aid schemes with the results of medical tests to confirm that they are in fact HIV-positive. Medical aid schemes have a duty to keep all medical conditions confidential. Therefore, most schemes have a dedicated or outsourced chronic-management department which assists only patients with chronic conditions. Such departments are usually guided by the HIV and TB care programme of the scheme concerned.

The MSA makes provision for a complaints procedure to cater for complaints by medical scheme members, providers of healthcare services and contractors to medical schemes:[45]

- All complaints must be in writing and registered with the scheme concerned. Unresolved complaints can be referred to the Registrar of Medical Schemes;
- Complainants dissatisfied with the outcome can lodge an appeal with the CMS against the decision of the Registrar.
- Should the issue remain unresolved, the complainant or respondent can lodge an appeal against the Council's decision with the Appeal Board constituted in terms of the MSA.

Although complainants and respondents are allowed to seek recourse to the courts, the MSA's alternative dispute resolution process offers a faster and cheaper way of resolving matters.

When legal practitioners assist a client, who is a member of a medical aid scheme with an issue related to access to health, it is essential that they review the MSA and relevant regulations. This includes assessing what the member is entitled to under his or her particular cover. No medical aid scheme may discriminate against anyone on the basis of his or her HIV and TB status and all members of medical aid schemes are entitled to receive ARV and TB treatment. Medical aid schemes are not allowed to change any of their rules without registering the amended rules with the Registrar of the CMS.

5. General Complaints Procedure

The rights of users of a healthcare system as articulated in policy and legislation would be meaningless if 'there was no accessible way to ensure that those who do not respect them are held to account'.[46] However, rights also come with certain responsibilities that users of the healthcare system must respect to in terms of the NHA.

Patients have an obligation to respect the rules of the healthcare establishment concerned, respect and co-operate with healthcare providers by giving

43. S 29A(2)(a) of the MSA. See also Annexure A to the MSA regulations which states that 'The objective of specifying a set of Prescribed Minimum Benefits within these regulations is two-fold: (i) To avoid incidents where individuals lose their medical scheme cover in the event of serious illness and the consequent risk of unfunded utilisation of public hospitals. (ii) To encourage improved efficiency in the allocation of Private and Public health care resources. The Department of Health recognises that there is constant change in medical practice and available medical technology. It is also aware that this form of regulation is new in South Africa. Consequently, the Department shall monitor the impact, effectiveness and appropriateness of the Prescribed Minimum Benefits provisions. A review shall be conducted at least every two years by the Department that will involve the Council for Medical Schemes, stakeholders, Provincial health departments and consumer representatives. In addition, the review will focus specifically on development of protocols for the medical management of HIV/AIDS. These reviews shall provide recommendations for the revision of the Regulations and Annexure A on the basis of (i) inconsistencies or flaws in the current regulations; (ii) the cost-effectiveness of health technologies or interventions; (iii) consistency with developments in health policy; and (iv) the impact on medical scheme viability and its affordability to Members.'

44. A Hassim, M Heywood and J Berger Health and Democracy: *A Guide to Human Rights, Health Law and Policy in Post-apartheid South Africa* (Cape Town: Siber Ink, 2007) at p. 238.

45. See ss 47–50 of the MSA.

46. Op cit note 47 at p. 265.

accurate information about their health status, and sign and discharge certificates releasing the healthcare establishment from liability if they refuse to accept the recommended treatment.[47]

Any person can hold healthcare establishments and healthcare providers to account by filing complaints as set out in legislation, by councils and in terms of the health establishment complaints procedure. In terms of section 18 of the NHA, any person 'may lay a complaint about the manner in which he or she was treated at a health establishment and have the complaint investigated'.[48] An obligation rests on the relevant member of every provincial Executive Council and on every municipal council to establish a complaints procedure.[49] Every health establishment must display the procedure so that anyone entering the establishment can see it.[50] Complaints about private health establishments are to be lodged with the head of the establishment concerned. Therefore, anyone wishing to complain about a refusal to initiate ART and TB treatment , for example, ought always in the first instance to follow the complaints procedure at the relevant hospital.

Complaints related to members of the HPCSA can be lodged with the HPSCA itself. The Council provides a list of healthcare providers that are members of the Council. Complaints about nurses who act negligently or unethically or simply refuse to treat an HIV-positive patient can be lodged with the South African Nursing Council for investigation. Complaints about alternative health practitioners can be reported to the Allied Health Professions Council of South Africa for investigation. All councils provide guidelines on and procedures for lodging complaints against health-care workers.

Complaints can also be lodged with the OHSC which was established to protect and promote the health and safety of users of health services. The mandate of the OHSC is to monitor and enforce compliance by health establishments with norms and standards prescribed by the Minister of Health in relation to the national health system and to ensure 'consideration, investigation and disposal of complaints relating to non-compliance with prescribed norms and standards for health establishments in a procedurally fair, economical and expeditious manner'.[51] The OHSC houses the complaints management unit, the Ombud which has powers:

- To investigate all complaints related to breaches of norms and standards from all health establishments both public and private.
- To make recommendations to healthcare establishments regarding breaches identified.
- To refer any complaint that the Ombudman feels needs to be investigated and managed by a regulatory body.[52]

Any healthcare user of a healthcare establishment in South Africa can lodge a complaint. A complaint can also be lodged on behalf of a relative or minor or any other person including whistle-blowers.

6. Conclusion

TB's co-morbidity with HIV poses a serious challenge in the fight against HIV and makes a comprehensive plan tackling both TB and HIV essential. The NSP 2017–2022 is aimed at addressing social and structural barriers that increase vulnerability to HIV and TB infection and at preventing new HIV and TB infections. Legal practitioners can assist in recording social and challenging structural barriers, which will help in holding accountable those responsible for violations of the right to access healthcare. In advising PLHIV and those infected with TB, they can raise awareness on the right to access healthcare and ensure access to legal services. The right of access to healthcare services is not absolute but realised over time taking into account the availability of resources.

47.. Ibid. at p. 264.

48. S 18(1).

49. S 18(2).

50. S 18(3)*(a).*

51. See the mandate of the OHSC at http://www.ohsc.org.za/index.php/who-we-are/mandate.

52. See http://www.ohsc.org.za/index.php/overview-on-complaints-management/22-complaints/85-ohsc-complaints-management-unit.

SUB-CHAPTER 4.1: WOMEN

1. Introduction

Women's human rights are fundamental human rights. The protection of women's human rights in the fight against Human Immunodeficiency Virus (HIV) and Tuberculosis (TB) entails:[1]

- developing laws and policies that do not prohibit women from equal access to land, property, and housing;
- promoting gender equality;
- giving equal access to economic and social opportunities;
- eliminating gender-based violence; and
- granting access to sexual and reproductive health rights.

Gender inequality plays a significant role in perpetuating both the HIV and TB epidemics.[2] TB is known to affect men more than women. However, it has severe consequences for women, especially during their reproductive years and specifically during pregnancy.[3] An estimated 19 % of adults (ages 15-29) in South Africa are living with HIV and a large proportion of this percentage are women. The HIV epidemic disproportionately affects women compared to males, and is highest among black African women.[4] It is important to note, however, that the infection rate among young women appears to be decreasing while the prevalence rate among older women is increasing.[5] Safer sex practices among young women appear to be having a positive impact on the infection rate, while social and cultural circumstances contribute to the high infection rate among older women, particularly married women or those in long-term relationships.[6]

2. The Relationship Between Gender Equality and HIV and TB

Gender equality 'reflects the idea that all human beings, both men and women, are free to develop personal abilities to make choices without any limitations set by stereotypes, rigid gender roles or prejudices.'[7] The relationship between gender inequality and the spread of HIV is the result of a 'complex interaction' of factors including the economic dependence of women on men; the survival strategies of women such as intergenerational sex, sex work, and early marriage in conditions of poverty; the use of contraception, and historical and cultural gender traditions and attitudes that shape the sexual behaviour of men and women.[8] Gender relations, power imbalances, harmful social gender norms, violence against women and marginalisation of women all serve to increase women's vulnerability to HIV infection.[9] In addition, women's increased biological vulnerability is compounded by their subordinate social status.[10]

Numerous studies also demonstrate that partner violence increases the risk of HIV infection.[11] Women who are beaten or dominated by their partners are much more likely to become infected with HIV than women who are not.[12] Violence against women makes it difficult for women to negotiate condom use, safe sex or the timing of sex.[13] In many communities, social norms dictate

1. UNHR Office of the High Commission "Women's human rights and gender equality" https://www.ohchr.org/EN/Issues/Women/WRGS/Pages/WRGSIndex.aspx.
2. Mabaso, M., Makola, L., Naidoo, I. et al. HIV prevalence in South Africa through gender and racial lenses: results from the 2012 population-based national household survey. Int J Equity Health 18, 167 (2019). https://doi.org/10.1186/s12939-019-1055-6 at pg 2
3. World Health Organisation "Tuberculosis in Women" https://www.who.int/tb/challenges/hiv/tb_women_factsheet.pdf
4. Ibid.
5. Ibid.
6. A Vukeya Motsepe (ed) HIV and the Law: A Practitioners Guide (Durban: LexisNexis, 2016) at pg 146.
7. South Africa's National Strategic Plan for HIV, TB and STI's 2017 -2022 at 103.
8. Op cit note 6.
9. Ibid.
10. Ibid.
11. UNAIDS 'The gap report 2014: Adolescent girls and young accessed on women'http://www.unaids.org/sites/default/files/media_asset/02_Adolescentgirlsandyoungwomen.pdf.
12. KL Dunkle, RK Jewkes, HC Brown et al. 'Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa' *The Lancet* 363(9419) (2004): 1415–1421.
13. 'Women and HIV/AIDS', http://www.avert.org/women-hiv-aids.htm.

that, while women must remain monogamous, men are allowed and even encouraged to engage in sex with multiple partners.[14]

In addition, '[m]arriage does not always protect a woman from becoming infected with HIV. Many new infections occur within marriage or long-term relationships as a result of unfaithful partners.'[15] The financial dependence of one partner on the other makes it difficult for the dependant partner with HIV to disclose his or her HIV status and encourage the use of condoms for fear of rejection and loss of financial support. This is especially a problem for dependant partners who know that their partner is having unprotected sex with other people outside the relationship. These problems are exacerbated for people who are in violent relationships.[16] Economically vulnerable people are less likely to terminate a violent or dangerous relationship, less likely to have access to information regarding HIV, less likely to use condoms and more likely to resort to high-risk behaviour to secure a source of income.[17]

Women's insecure employment circumstances exacerbate their economic dependence and thus increase their vulnerability to HIV. For example, fewer women than men are employed, and women generally have less job security and are paid less than men.[18] The COVID-19 pandemic has exacerbated this reality for many women who have been disproportionately impacted by the shrinking economy that results in job losses and loss of livelihoods.[19] These patterns of dependence promote relationships in which men are the decision-makers in key areas related to HIV prevention including sexual relations, the use of protection, household spending on health, and access to healthcare.[20] In addition, the denial of women's inheritance and property rights can increase their vulnerability to HIV.[21] Not being able to own property means that women have limited economic stability. This can lead to an increased risk of sexual exploitation and violence in that women may have to endure abusive relationships or resort to informal sex work for economic survival.[22]

In the case of TB, women may be unable to 'initiate the seeking of TB diagnosis or treatment for themselves or other family members because of economic subordination in the household.'[23] Women often carry the burden of taking care of children which results in missing medical appointments for treatment of TB. Moreover, health services for women in prison or detention are often inferior to those in men's facilities[24] and this too can lead to increased exposure to TB.

14. International Planned Parenthood Federation 'The truth about men, boys and sex: Gender transformative policies and programmes' (2009) at p. 7.

15. 'Women and HIV/AIDS', http://www.avert.org/women-hiv-aids.htm.

16. UNAIDS 'Gender and HIV/AIDS: UNAIDS technical update' (1998), http://data.unaids.org/publications/irc-pub05/jc459-gender-tu_en.pdf; UNAIDS 'Report on the global HIV/AIDS epidemic – June 2000' (2000), http://data.unaids.org/pub/Report/2000/2000_gr_en.pdf. See also RK Jewkes, K Dunkle, M Nduna and N Shai 'Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa: A cohort study' *The Lancet* 376(9734) (2010): 41–48

17. A Blanc 'The effect of power in sexual relationships on sexual and reproductive health: An examination of the evidence', *Studies in Family Planning* 32(3) (2001): 189–213.

18. Mindry, S Maman, A Chirowodza et al. 'Looking to the future: South African men and women negotiating HIV risk and relationship intimacy' *Culture, Health & Sexuality* 13(5) (May 2011): 589–602.

19. UNWomen 'COVID -19 and its Economic Toll on Women: The Story Behind the Numbers' published on 6 September 2020 at https://www.unwomen.org/en/news/stories/2020/9/feature-covid-19-economic-impacts-on-women accessed on 14 October 2020.

20 Pan-American Health Organisation 'The UNGASS, gender and women's vulnerability to HIV/AIDS in Latin America and the Caribbean' (2002), http://www1.paho.org/English/ad/ge/genderandhiv-revised0904.pdf (accessed February 2015) at p. 12.

21. AIDS Accountability International 'Fact sheet on women and HIV/AIDS', http://www.aidsaccountability.org/wp-content/uploads/2009/11/fact-sheet-o-women-and-hivaids.pdf, at p. 1, citing UNDP 'HIV and women's inheritance and property rights' (2009), http://content.undp.org/go/newsroom/updates/hiv-www-news/womens-inheritance-and-property-rights-areessential-to-effective-aids-response.en?src=print.

22. UNAIDS 'Global report: UNAIDS report on the global AIDS epidemic 2010', http://www.unaids.org/globalreport/Global_report.htm.

23. Open Society Foundations, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and Stop TB Partnership, in collaboration with UNAIDS & the O'Neill Institute for National and Global Health Law 'Tuberculosis and Human Rights: Prepared for a side event on human rights and TB preceding the UN General Assembly high-level meeting on ending TB' 24 September, 2018 at pg 4.

24. Ibid.

3. Women and the Law in South Africa

The Constitution of South Africa recognises woman as equal citizens and therefore promotes gender equality. There are a number of provisions in the Constitution that protects the rights of women, however, section 9 of the Constitution entitles women to the right to equality. Specifically, section 9(3) states that:

'The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth.' The specific prohibition of discrimination on the grounds of gender, sex, pregnancy and marital status is clearly intended to protect women.[25] In light of these specific grounds, the following legislation is relevant in the protection of the rights of women:

3.1. Protection Against Violence

3.1.1. The Criminal Law (Sexual Offences and Related Matters) Amendment Act[26]

Violence against women is acknowledged by many experts as having reached epidemic proportions in South Africa.[27] The Criminal Law (Sexual Offences and Related Matters) Amendment Act of 2007[28] reformed and codified the law relating to sex offences. The Act repealed various common law crimes including rape and indecent assault and replaced them with statutory crimes defined on a gender-neutral basis. It expanded the definition of rape, previously limited to vaginal sex, to include all non-consensual penetration; and it equalised the age of consent for heterosexual and homosexual sex at 16. The Act provides various services to the survivors of sexual offences, including free post-exposure prophylaxis for HIV, and the ability to obtain a court order to compel HIV testing of the alleged offender. In addition, it created the National Register for Sex Offenders which records the details of those convicted of sexual offences against children or people who are mentally disabled.

3.1.2. The Domestic Violence Act[29]

The Domestic Violence Act was promulgated to protect people against violence. The legislation broadens the definition of domestic violence to include not only married women and children, but unmarried women who are involved in relationships or living with their partners, people in same-sex relationships, mothers and their sons, and other people who share a living space. This Act set out the law enforcement duties to properly investigate a domestic violence scene. It recognises that abuse may take many different forms, namely:

- domestic violence;
- sexual abuse;
- economic abuse; and
- emotional and psychological abuse.

Under this Act, a survivor of domestic violence can lay a criminal charge and obtain a protection order. A civil claim for pain and suffering and for medical costs can also be lodged and a claim made against the State for failure to protect the rights of women against violence.

An example of case where a civil claim was lodged against the State, is the landmark Constitutional Court case of *Carmichele v Minister of Safety and Security and another*,[30] the applicant sued the state for damages resulting from a brutal attack on her by a man who was awaiting trial on charges of having attempted to rape another woman. Despite the man's history of sexual violence, the police and the prosecutor had recommended his release without bail. The applicant alleged that this had been a wrongful omission. She also relied on the duties imposed by the rights to life, equality, dignity, freedom and security of the person, and privacy. The High Court said she had not established that the police or

25. South African History Online "Women's Rights and Representation" https://www.sahistory.org.za/article/womens-rights-and-representation Last Updated 27 August 2019.

26. Act 32 of 2007.

27. L Vogelman and S Lewis 'Gang rape and the culture of violence in South Africa', http://www.csvr.org.za/wits/papers/paplvsl.htm (accessed 1 October 2015); L Vetten 'Violence against women in South Africa' in S Buhlungu, J Daniel, R Southall and J Lutchman (eds) *State of the Nation, South Africa 2007* (Cape Town: HSRC Press, 2009) at p. 175; H Moffett '"These women, they force us to rape them": Rape as narrative of social control in post-apartheid South Africa' *Journal of Southern African Studies* 32(1) (2006): 129–144.

28 Act 32 of 2007.

29. Act 116 of 1998

30. 1996 (6) SA 197 (CC).

the prosecutor had wrongfully failed to fulfil a legal duty owed specifically to her. On appeal the Supreme Court of Appeal held that the police and prosecution had no legal duty of care towards her and could not be held liable. The Constitutional Court, however, granted the application for leave to appeal and upheld the appeal. Regarding the police, the Court held that the State was obliged to prevent gender-based discrimination and to protect the dignity, freedom and security of women. Similarly, the Court held that prosecutors, under a general duty to place before a court any information relevant to the refusal or granting of bail, might reasonably be held liable for negligently failing to fulfil that duty.

3.2. Gender Equality

3.2.1. Promotion of Equality and Prevention of Unfair Discrimination Act[31]

The Promotion of Equality and Prevention of Unfair Discrimination Act seeks to advance equality in public and private spheres. It provides a framework to tackle unfair discrimination, harassment and hate speech, and works towards the transformation of South African society in line with the ideals expressed in the Constitution. It prohibits unfair discrimination on any grounds listed in the Bill of Rights. The Act provides for the establishment of Equality Courts.

3.3. Equality in Marriage

3.3.1. The Recognition of Customary Marriages Act[32]

Under apartheid, customary unions did not enjoy the same legal status as that of civil marriages. This discriminatory practice was remedied by the enactment of the Recognition of Customary Marriages Act[33] (RCMA), which became law on 15 November 2000. The Act also recognises polygamy.[34]

The Act creates a set of rules governing customary marriages and creates certain legal obligations and protections for parties to the marriage. It also sets out the rules for a proper customary marriage: both parties must be over the age of 18, both must consent to be married under customary law and the marriage must be valid under the relevant provisions of customary law.[35] The Act gives full legal recognition to customary marriages[36] and gives all partners to a customary marriage equal status and legal capacity within the marriage, including the capacity to acquire and dispose of assets, enter into contracts and litigate.[37]

Customary marriages are automatically in community of property unless the parties enter into an ante-nuptial contract.[38] The RCMA also provides that customary marriages can be dissolved by an order of court only and that the provisions of the Divorce Act[39] and the Mediation in Certain Divorce Matters Act[40] apply to customary marriages.[41] A woman who wishes to end a polygamous marriage is entitled to claim her share of the joint property of the marriage on divorce.[42] Women are also entitled to claim maintenance on divorce, but the courts are entitled to take into account any *lobola* payments made.[43]

The role of the Recognition of Customary Marriages Act in reducing women's vulnerability to HIV

- The minimum-age and consent requirements for a valid marriage in terms of the RCMA will help to protect girls from being forced into early marriages that may put them at risk of HIV infection.

31. Act 4 2000.
32. Act 120 of 1998.
33. Ibid.
34. S 7(6) and (7).
35. S 3(1).
36. S 2.
37. S 6.
38. S 7(2).
39. Act 70 of 1979.
40. Act 24 of 1987.
41. S 8(1)–(3) of the RCMA.
42. S 8(4).
43. bid.

- The equal legal status granted to women married under the Act will encourage the ability of women to own property in their own name and to enter into contracts which will enhance their economic independence and help them to leave risky relationships which put them at risk of HIV infection.
- The economic independence of women is further enhanced by the fact that customary marriages are in community of property, giving women a right to the common property of the marriage and the right to inherit from the marriage under the rules of intestate succession. Allowing women to claim maintenance on the dissolution of a customary marriage also reduces their economic vulnerability.

Although the RCMA recognises polygamy, it goes some way towards protecting women by giving them the choice to end the polygamous relationship (which could put them at risk of HIV infection) by allowing them to claim their fair share of the common property on divorce.

3.3.2. Intestate Succession Act[44] and Maintenance of Surviving Spouses Act[45]

There is a link between the prevalence of HIV among women and 'laws that inhibit the full enjoyment of women's rights to land ownership and inheritance'.[46] In the pre-apartheid era, for example, section 23 of the Black Administration Act[47] established the rule of male primogeniture[48] in inheritance among black South Africans, a move which was detrimental to women and girls. With the advent of the HIV pandemic the detrimental effect of primogeniture became more marked, particularly for women and girls infected with HIV. Under this law, women were robbed of their marital assets at the passing of their husbands by his relatives who left them destitute and more vulnerable to HIV.

In *Bhe and others v Magistrate, Khayelitsha, and others* (Commission for Gender Equality as amicus curiae); *Shibi v Sithole and others; South Africa Human Rights Commission and another v President of the Republic of South Africa and another*[49] the Constitutional Court held section 23 of the Black Administration Act and the regulations enacted in terms of that Act, together with the rule of male primogeniture in South African customary law of succession, to be unconstitutional. The effect of the Bhe case is that all intestate estates which are subject to South African customary law must be transferred to heirs or beneficiaries in terms of the Intestate Succession Act[50] under which the estate of a decedent will benefit a spouse regardless of the surviving spouse's gender and legitimacy of the decedent's children.[51] Subsequently, the Reform of Customary Law of Succession and Regulation of Related Matters Act[52] was enacted to give effect to the judgment in the *Bhe* case.

In *Daniels v Campbell No and Others*,[53] the applicant was married to her husband according to Muslim rites in 1977. The marriage was not solemnised under the civil law. When the applicant's husband died intestate in 1994, the house in which they lived was transferred to the deceased estate. The applicant was told that she could not inherit from the estate because she did not qualify as a "surviving spouse". The applicant approached the High Court, which held that "spouse" could only be applied to people married according to South African law and did not include people married according to Muslim rites. The High Court found that this interpretation violated the

44. Act 81 of 1997.

45. Act 27 0f 1990.

46. UN Commission on Human Rights 'Women's equal ownership, access to and control over land and the equal rights to own property and to adequate housing', Resolution 2005/25, UN Doc. E/CN.4/2005/RES/25, 15 April 2005, quoted in S Chu and A Symington *Respect, Protect and Fulfill: Legislating for Women's Rights in the Context of HIV/AIDS* Vol. 2: Family and Property Issues, Module 3: Property in Marriage (Toronto: Canadian HIV/AIDS Legal Network, 2009) at p. 3-3.

47. Act 38 of 1927.

48. According to this rule black African women and minor children could not inherit from their male relatives.

49. 2005 (1) SA 580 (CC).

50. Act 81 of 1987.

51. AIDS and Human Rights Research Unit Human Rights Protected? Nine Southern African Country Reports on HIV, AIDS and the Law (Pretoria: Pretoria University Law Press, 2007) at p. 264.

52. Act 11 of 2009.

53. 2004 (5)SA 331 (CC).

applicant's rights to practise her religious and cultural beliefs, and ordered that words be read in to the Intestate Succession Act and the Maintenance of Surviving Spouses Act to give her the relief she sought. The Constitutional Court held that the word 'spouse' included parties to a Muslim marriage and that the objective of the acts was to protect widows. Therefore, there was no reason why the principles of the right to equality under the statutes should not apply to Muslim widows. The Court further held that the exclusion of people married under Muslim rites was unjustifiably discriminatory, therefore people married according to Muslim rites were spouses for the purposes of inheriting or claiming from estates where the deceased died without leaving a will.

In *Brink v Kitshiff No*,[54] the Constitutional Court had to decide whether Section 44 of the Insurance Act of 1943 deprived married women, but not married men, of all or some of the benefits of life insurance policies made in their favour by their husbands. The Constitutional Court held that section 44 discriminated against married women on the basis of sex and marital status, and was thus a violation of the equality clause. Married men did not lose the benefits of insurance policies ceded to them or made out in their favour by their wives.

The Court held that, since the common-law rule prohibiting donations between spouses had been abolished, the argument that the section provided married women with a benefit was no longer applicable. The Court also rejected the argument that the section was necessary to prevent collusion between spouses: such collusion could as easily occur where husbands rather than wives were beneficiaries.

In the *Bwanya* case the High Court declared section 1(1) of the Intestate Succession Act to be unconstitutional in so far as it omits the inclusion after 'spouse' of 'or a partner in a permanent opposite-sex life partnership in which the partners had undertaken reciprocal duties of support.' The declaration of invalidity will stand over for confirmation by the Constitutional Court.[55] If the declaration of unconstitutionality is confirmed by the Constitutional Court, the impact will counter the vulnerability of women in domestic partnerships who are often exploited and left without recourse or remedy at the end of such relationships because of the lack of legal recognition and protection afforded to them.[56]

3.4. Sexual and Reproductive Health

The right to reproductive health is firmly entrenched in section 27(1)(a) of the Constitution which provides that '[e]veryone has the right to have access to . . . healthcare services, including reproductive healthcare'. Furthermore, section 12(2) of the Constitution pronounces the right to physical and bodily integrity. It states that [e]veryone has the right to bodily and psychological integrity, which includes the right –

(a) to make decisions concerning reproduction;
(b) to security in and control over their body; and
(c) not be subjected to medical or scientific experiments without their informed consent.

This right also applies to HIV positive women who wish to have children. The National Department of Health Policy gives pregnant women with HIV access to services in antenatal clinics aimed at preventing mother-to-child transmission of HIV. In 2014, South African National Department of Health released revised guidelines on the prevention of such transmission.[57] These guidelines advise HIV-positive pregnant women to start ART treatment 'with appropriate counselling from their first antenatal visit regardless of gestational age' or baseline CD4 cell count.[58] These guidelines are revised regularly to be in line with the World Health Organization (WHO) guidelines.

TB remains the most common cause of death from infectious agents in childbearing-age women (14 to 49 years) worldwide.[59] If left untreated TB create greater health hazard to a pregnant woman and her unborn baby

54. 1996 (6) SA 197 (CC).

55. *Bwanya v Master of the High Court, Cape Town and Others* (20357/18) [2020] ZAWCHC 111 (28 September 2020)

56. Womens Legal Centre ' The Bwanya Statement: A Win For #Equalityinrelationships' published on 30 September 2020 accessed at https://wlce.co.za/the-bwanya-statement/ 0n 14 October 2020.

57 'National consolidated guidelines for the prevention of mother-to-child transmission of HIV (PMTCT) and the management of HIV in children, adolescents and adults', December 2014, http://www.sahivsoc.org/upload/documents/ART%20Guidelines%2015052015.pdf.

58. Ibid. at s. 6.1.1.

59. Newton, E, Glob. libr. women's med.*(ISSN: 1756-2228)* 2008; DOI 10.3843/GLOWM.10186.

than does the fetus.[60] It is suggested that TB should be initiated whenever the probability of TB is moderate to high.[61] The South African National TB Guidelines for Adults recommend standard TB treatment for the prevention of active TB in HIV-infected pregnant women.[62]

3.4.1. The Choice of Termination of Pregnancy Act[63]

The Choice of Termination of Pregnancy Act was enacted to reform the abortion law in order to improve the health of women and prevent deaths among women due to illegal abortions.[64] This was a significant step in respecting the rights of women to choice and to bodily integrity.

Termination of pregnancy[65] is the ending of a pregnancy, before full term, by medical or surgical means. There are many reasons why a woman may not be able or want to continue with a pregnancy. The pregnancy may be the result of rape or incest or a casual relationship with no prospects of marriage. Some women are simply not emotionally prepared to be parents at the time (this includes married women) or are too young. In other instances, women have to choose between continuing with their studies or dropping out of school to take care of a child and risk the prospects of being financially insecure in the future. Whatever the reasons, the right to reproductive health as stipulated in section 27(1)(a) of the Constitution gives a woman the choice to terminate her pregnancy or give birth.

In South Africa, The Choice of Termination[66] of Pregnancy Act[67] gives women the right to safe and legal terminations and the National Health Act[68] gives women the right to access free terminations. The conditions under which a pregnancy can be terminated are divided into three gestational periods:

- Up to and including 12 weeks gestation by dates.
- Above 12 weeks up to and including 20 weeks gestation by dates.
- Above 20 weeks gestation by dates.

The Act allows doctors and midwives who are skilled to terminate a pregnancy up to and including 12 weeks gestation. Only doctors are allowed to terminate pregnancies above 12 weeks under certain conditions. The Act has thus reduced the upper limit from the 28 weeks that is traditionally accepted as the cut-off point for viability.[69] The Act also governs the termination of pregnancy up to and including viability, thus including induction of labour and caesarean section.

Section 5 of the Choice on Termination of Pregnancy Act states that a 'Woman of any age can consent to a termination of her pregnancy and only her consent is required'. A child under the age of 18 can be advised by a midwife or a doctor to speak to her parents or guardian before she undergoes the procedure but does not have to do so to access this service. This is one of the features of the Act which respect women's right to choose, irrespective of their age. Termination of pregnancy will not be denied even if a child chooses not to inform anyone.[70] Section 5 'was deemed necessary given that there are children who may have been sexually abused by their guardians or parents'.[71]

3.4.1.1. Denial of Access to Abortion Services

The termination of pregnancy brings to the fore morality debates which are linked to religious and spiritual beliefs. The Choice of Termination of Pregnancy Act was challenged by a religious organisation on the ground that

60. Centers for Disease Control and Prevention " Treatment for TB Disease and Pregnancy" accessed from https://www.cdc.gov/tb/topic/treatment/pregnancy.htm on 13 October 2020.
61. Ibid.
62. South African National TB Guidelines accessed from 'http://www.mic.uct.ac.za/sites/default/files/image_tool/images/51/TB%20Adult.pdf on 2 June 2020.
63. Act 92 of 1996
64. RE Mhlanga "Abortion: developments and impact in South Africa" *British Medical Bulletin* 2003; 67: 115–126 *British Medical Bulletin*, Vol. 67 The British Council 2003; all rights reserved DOI: 10.1093/bmb/ldg006 at 116.
65. TOP for short, or abortion.
66. Abortions – Reasons for Abortions accessed from at http://family.jrank.org/pages/2/Abortion-Reasons-Abortions.html at 5 June 2020.
67. Act 92 of 1996.
68. Act 61 of 2003.
69. Op cit note 69 at 118
70. Ibid
71. Ibid at 118 - 9

its liberal provisions are tantamount to a violation of the right to life of a foetus under the Constitution in *Christian Lawyers Association of SA and Others v Minister of Health and Others.*[72] The Court held that the Constitution did not include any provisions granting foetal personhood.

Regardless of the rights provided in the Choice of Termination Of Pregnancy Act women are still denied access to safe abortions by medical practitioners who invoke the right to conscientious objection. This denial has led to women resorting to keeping an unwanted child or having backstreet abortions as an option after being turned away. Rural women in particular are disadvantaged in that they often travel long distances to urban centres to have abortions. A study of young women in Johannesburg Soweto, found that most women knew where to obtain sexual and reproductive rights information and services but 'that common experiences of providers' unsupportive attitudes, power dynamics in relationships, and communication issues with parents and community members prevented [women] from accessing and using the information and services they needed.'[73]

Conscientious objection is commonly used to describe the actions of doctors or nurses who will not perform abortions because this violates their personal or religious beliefs.[74] Section 15 of the Constitution which, inter alia, guarantees the right to freedom of conscience, implicitly accommodates the right to conscientious objection to abortion. The right to conscientious objection is not, however, absolute. It can be limited by section 36 of the Constitution.

Simply described, section 36 can limit the health workers right to freedom of conscience in the following ways. It can:[75]

- Impose a duty to inform: Health workers can refuse to participate in an abortion in non-emergency situations, but they must explain their decision to patients in a non-stigmatising way while affirming that a patient has a right to terminate her pregnancy. Health workers must make the necessary arrangements to enable the patient to be seen by another health worker who can provide the abortion.[76]
- Impose as duty to save a life and prevent serious damage to health: Health workers are not allowed to invoke this right where non-attendance of a pregnant woman in emergency cases would endanger her life or seriously damage her health.[77]

In a healthcare setting it would be a violation of the rights to access to healthcare, human dignity and life if a healthcare provider were to (i) refuse access to abortion services where a pregnant woman is in need of emergency care or (ii) refuse to give relevant information to the women including a referral in non -emergency situations.

3.4.2. The Sterilization Act[78]

The Sterilisation Act regulates sterilisation in South Africa. It provides for 'sterilisation of a person in circumstances where the person's mental or physical health is threatened, and where the sterilisation is in the best interest of the person'.[79] Sterilisation is a procedure done to ensure that the person sterilised cannot have children. It has been reported that in some instances, women being sterilised are unaware or do not understand that they are being asked to give consent to sterilisation.[80]

In terms of section 2(1), a person who is 18 years old or older, who is capable of consenting, can consent on his or her own to sterilisation. Sterilisation may not be

72. 1998 (11) BCLR 1434 (T)

73. L ince-Deroche, N, Hargey, A, Holt, K, Shochet, T (2015) 'Accessing sexual and reproductive health information and services: A mixed methods study of young women's needs and experiences in Soweto, South Africa', African Journal of Reproductive Health, Volume 19, Issue 1, p73-81 https://www.avert.org/professionals/hiv-social-issues/key-affected-populations/women#footnote27_n4lwagi

74. Abortion in South Africa "A Reporting guide for Journalists" also see Mary Favier Jamie M.S. Greenberg "Safe abortion in South Africa: "We have wonderful laws but we don't have people to implement those laws" (30 October 2018)

75. C Ngwena 'Conscientious objection and legal abortion in South Africa: delineating the parameters' 2003 Journal for Juridical Science 28(1):1-18 at page 5

76. Ibid

77. Ibid at p.11

78. Act 44 of 1998.

79. A Hassim, M Heywood and J Berger (eds) *Health and Democracy: A Guide to Human Rights, Health Law and Policy in Post-Apartheid South Africa* (Cape Town: Siber Ink, 2007) at p. 367.

80. LC McLaughlin 'The price of failure of informed consent law: Coercive sterilizations of HIV-positive women in South Africa' *Law and Inequality* 32(1) (2014): 69–93 at p. 69.

performed on anyone under the age of 18 unless failure to do so would jeopardise that person's life or seriously impair his or her physical health.[81] Informed consent is the most important requirement for sterilisation. According to section 2(2) of the Sterilisation Act, no one may be sterilised without his or her consent unless he or she is unable to consent. It is therefore unlawful to sterilise a woman with HIV unless she agrees that she wants to be sterilised. For purposes of the Act, 'consent' means consent given freely and voluntarily without any inducement and may only be given if the person giving it has –

(a) been given a clear explanation and adequate description of the:
    (i) proposed plan of the procedure; and
    (ii) consequences, risks and the reversible or irreversible nature of the sterilisation procedure;
(b) been given advice that the consent may be withdrawn any time before the treatment; and
(c) understood and signed the prescribed consent form.[82]

There have been many occurrences of sterilisation of HIV-positive women around the World, including South Africa, in an attempt to prevent HIV positive women from becoming pregnant.[83] In February 2020, the Commission on Gender Equality released a report that confirmed instances in which women were allegedly either forced or coerced into agreeing to the procedure while giving birth.[84] The Commission on Gender Equality alluded to the fact that in these cases medical practitioners breached their duty of care. Women have been 'forced to relinquish their reproductive rights to obtain access to healthcare services, such as termination of pregnancy, labour and delivery care including Antiretroviral medication', if they do not agree to sterilisation.[85] This discriminatory behaviour by medical professionals is prompted by the perception that 'HIV positive women are irresponsible and unfit to have children due to their supposed heightened risk of early death'.[86] This approach disregards scientific research showing that women living with HIV can live long, productive and healthy lives and, with adequate access to services preventing mother-to-child transmission of HIV, can have healthy HIV-negative babies. If a woman with HIV chooses to get sterilised, the hospital concerned must respect her decision. She does not have to discuss her decision with her husband or obtain his consent. Any deviation from the above is a violation of the woman's right to reproductive health.

3.4.2.1. Involuntary Sterilisation and Criminal Law

Criminal law can be utilised in prosecuting doctors within the reproductive healthcare setting and in relation to consent requirements under the common-law crime of assault as the relevant crime applicable to involuntary sterilisations.[87] Assault is defined as 'unlawful and intentional application of force to the person of another or inspiring a belief that force will be immediately applied. Any conduct applied to the person of another will constitute assault if it intentionally causes an impairment of a person's bodily integrity.'[88] Since access to reproductive healthcare service entails the realisation of freedom of reproductive choice and promotes the right to bodily and psychological integrity, reproductive health, dignity and equality for women, involuntary sterilisation can thus constitute assault. The definition of assault as described above can be situated under these rights.

The common-law crime of assault is available to women who were sterilised prior to the enactment of the Sterilisation Act 44 of 1998, provided that the crime has not been prescribed in terms of section 18 of the Criminal Procedure Act 51 of 1977. For those women who were

81. S 2(3)(a).

82. Act 44 of 1998 at s4.

83. S Mthembu, Z Essack and A Strode '"I feel like half a woman all the time": A qualitative report of HIV-positive women's experiences of coerced and forced sterilisations in South Africa' (December 2011), http://africawln.org/wp-content/uploads/2012/06/HIV-Women-being-sterilized.pdf, at p. 16 (accessed January 2015). See also 'HIV Positive woman say forced sterilisation add insult to Injury', *City Press* (18 March 2015), http://www.news24.com/Archives/City-Press/HIV-positive-women-say-forced-sterilisation-adds-insult-to-injury-20150430. See also

84. Commission on Gender Equality complaint No 414/03/2015 KZN. from www.cge.org.za. Accessed 22 April 2020. See also Forced Sterilizations of HIV-Positive Women: A Global Ethics and Policy Failure Stephanie Bi and Tobin Klusty https://journalofethics.ama-assn.org/article/forced-sterilizations-hiv-positive-women-global-ethics-and-policy-failure/2015-10

85. Ibid. at page. 73.

86. Ibid.

87. Camilla Pickles "Involuntary contraceptive sterilisation of women in South Africa and the criminal law" *SACJ* (2016) 2

88. Ibid p. 9

sterilised after the enactment of the Sterilisation Act 44 of 1998, section 9, together with subsection 2 and 4, and the common-law crime of assault are available, subject to the limitations of subsections 18 and 336 of the Criminal Procedure Act 51 of 1977.

Section 9 of the Act states that '[a]ny person who contravenes or fails to comply with the provisions of this Act is guilty of an offence and liable to conviction to a fine or imprisonment for a period not exceeding five years.' Section 2(2) provides that 'a person cannot be sterilised without his or her consent, provided he or she has the capacity to consent'.

Section 4*(a)* specifically requires that consent must be informed, in so far as the procedure, its nature (reversible or irreversible) and the consequences and risks are clearly and adequately explained to a woman. Section 4*(b)* and *(c)* provides that 'a consent form must be signed that reaffirms a patient's right to withdraw consent at any time before commencement of the sterilisation procedure.'

The issue of consent in involuntary sterilisation plays a significant role. In the Namibian case of *Government of the Republic of Namibia v LM*[89] three women living with HIV were sterilised after caesarean-section deliveries without consent. In this case all women signed the consent form. However, the court had to determine at which point these forms were signed and whether enough information was given to the women to make an informed decision. The hospitals had no record of whether the women had been given the necessary information so as to render their consent informed and voluntary. The women instituted civil action against the Namibian state, arguing that their sterilisations were unlawful because the procedures were performed without informed consent. The Supreme Court of Namibia found that signed consent forms are insufficient evidence of informed consent. The Court stated that 'Whether or not the respondents gave their informed consent to the sterilisation procedures is largely a factual question. For that reason, it requires a consideration of the circumstances in which the respondents allegedly gave their consent.'[90]

With regard to the time when the issue of sterilisation was raised with the women, the court found that signed consent was obtained while the women were in labour or when being taken to the theatre. Relying on the South African case of *Christian Lawyers Association v Minister of Health*[91] and *Castell v De Greef*[92] the court found that labour was an inappropriate time to obtain informed consent for sterilisations because the pain of labour and associated complications negatively impact women's capacity to consent.[93] The court held that:

> *'The consent obtained was invalidated by the respondents' lack of capacity to give informed consent in light of the history of how the decision to sterilise them was arrived at and the circumstances under which the respondents' consent was obtained. It was merely written rather than informed consent. ... The important factor which must be kept in mind at all times is whether the woman has the capacity to give her consent for sterilisation at the time she is requested to sign consent forms. Therefore, it is not decisive what information was given to her during antenatal care classes or at the moment she signed the consent form if she is not capable of fully comprehending the information or making a decision without any undue influence caused by the pain she is experiencing.'*[94]

In relation section 9 read with section 2 and 4, the role of the criminal law can and must be properly considered for a number of reasons:

- Involuntary sterilisations can be viewed as a form of public harm because performing medical procedures on a certain group within society without their consent is physically invasive and a grave violation of the right to bodily and psychological integrity, and deserves punishment.
- The state is obligated to promote, protect and fulfil the rights in the Bill of Rights. Thus, the state and its organs are first in line regarding the duty to act in cases of human rights violations. Involuntary

89. (SA 49/2012), [2014] NASC 19

90. Ibid para [49] and [52].

91. 1998 (11) BCLR 1434 (T)

92. 1993 (3) SA 501

93. Para 108

94. Ibid

sterilization can be described as obstetric violence (a gender-based violence).

In considering the criminal offence route, it will be important to note that Section 9 does not explicitly describe which form of fault, namely intention or negligence, is required. Navigating fault in these circumstances has been argued as follows:

There is a 'presumption that some degree of fault is required when interpreting statutory offences, and that the required form of fault is intention, unless there are express indications in the statute's language, context, scope or object that indicates to the contrary. According to Fannin J in *State v Naidoo*,[95] words such as 'negligently', 'without due care' or words that may resemble these terms may point to the intention of the legislature to broaden the scope of criminal liability to negligent conduct. Further, when determining whether negligence will suffice, *State v Naidoo* provides that 'to regard *culpa* as sufficient for criminal liability in statutory offences, involves an extension of criminal liability and an infringement of the fundamental rule of our law that criminal statutes should be benevolently construed in favour of individual freedom'. A reading of the Sterilisation Act 44 of 1998, in the light of guidance emanating from case law and academic commentary, suggests that [Section] 9 requires a measure of fault, especially given the use of 'fails to comply' in Section 9. Also, that intention is the required degree of fault because there is no express indication that the legislature intended to broaden liability to include negligent non-compliance with the provisions of the Act.'

3.4.2.2. Involuntary Sterilisation Civil Claim

A civil claim for damages can be lodged against a healthcare provider or health establishment for forced or involuntary sterilization without consent.

4. The Protection of Women Under International Law

While not a binding document, the Universal Declaration on Human Rights sets gender equality as an international norm. Gender equality has been codified in several international human rights documents that are binding on South Africa. The International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights provide for the rights to equality between men and women in the enjoyment of all rights. In addition, there are treaties and expert bodies specifically dedicated to the realization of women's human rights. The Convention on the Elimination of Discrimination Against Women (CEDAW) is considered the international bill of rights for women. The Convention defines what constitutes discrimination against women and sets an agenda for national action to end such discrimination. CEDAW was adopted by the United Nations in 1979 and came into force on 3 September 1981. In 1994 the United Nations resolved to appoint a Special Rapporteur – an independent expert – on the causes and consequences of violence against women. The Special Rapporteur investigates and monitors violence against women, and recommends and promotes solutions for its elimination. Article 2 of the African Charter on Human and Peoples' Rights[96] guarantees gender equality by recognising an entitlement to the enjoyment of the rights and freedoms recognised and guaranteed in the Charter without distinction of any kind, such as sex. The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa[97] expounds on this right further, acknowledging that addressing gender stereotypes is central to attaining gender equality. The Special Rapporteur on Rights of Women in Africa was established by the African Commission in April 1998.

See Chapter one on how to use international law as remedy in the protection of human rights.

95. 2009 (2) SACR 674

96. The African Charter on Human and Peoples' Rights http://www.achpr.org/instruments/achpr/ entered into force Oct. 21,1986.

97. The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa http://www.achpr.org/instruments/women-protocol/ entered into force Nov.25, 2005.

SUB-CHAPTER 4.2: CHILDREN

1. INTRODUCTION

In South Africa a 'child' is defined as a person under the age of eighteen years.[1] Similarly, Article 1 of the UN Convention on the Rights of the Child (CRC) defines a child as 'every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier'.[2] Any person under 18, unless married or emancipated by a court order, is a child and any person over 18 years is an adult. The CRC and the African Charter on the Rights and Welfare of the Child[3] regard children as a key and vulnerable group that need protection. In *S v M*,[4] the Constitutional Court emphasised 'that children are right bearers and not mere extensions of their parents, umbilically destined to sink or swim with them'.[5]

Section 28(1) of the Constitution of South Africa sets out a number of children's rights which include the right to:

- 'family care or parental care, or appropriate alternative care in the case of children removed from the family environment;
- basic nutrition, shelter, basic healthcare services and social services; and
- protection from maltreatment, neglect, abuse or degradation.'[6]

In addition to the rights set out in section 28(1), children are also entitled to the other rights in the Constitution, which include the right to basic education under section 29(1)(a) and the right to healthcare under section 27. Furthermore, section 28(2) of the Constitution provides that '[a] child's best interest are of paramount importance in every matter concerning the child.'[7]

In Teddy Bear *Clinic for Abused Children and Another v Minister of Justice and Constitutional Development and Another*[8] Khampepe J held that:

> 'Section 28(2) thus fulfils at least two separate roles. The first is as a guiding principle in each case that deals with a particular child. The second is as a standard against which to test provisions or conduct which affects children in general.'[9]

The South African National Strategic Plan for HIV, TB and STIs 2017-2022[10] states that 'children require a renewed focus, [because] for every child initiated on [antiretroviral therapy], there are approximately 1.4 new HIV infections.'[11] HIV affects children through:

a. Living with their own HIV infection;
b. Living with the infection, illness and loss of their parents; and
c. Living with the infection, illness and loss of those around them, such as friends, teachers or other family members.

Children who are at risk of contracting TB are children who:

a. live in a household with an adult who has active TB or has a high risk of contracting TB;
b. are infected with HIV or another condition that weakens the immune system;
c. come from communities that generally receive inadequate medical care; and
d. live in a shelter or are living with someone who has recently been released from prison.

1. For purposes of this chapter, a child is anyone under the age of 18 years. This is in accordance with the definition of 'child' in section 1 of the Children's Act 38 of 2005 and section 28(3) of the Constitution of the Republic of South Africa Act, 1996.
2. Adopted and opened for signature, ratification and accession by General Assembly resolution 44/25 of 20 November 1989 entry into force 2 September 1990, in accordance with article 49. https://www.ohchr.org/en/professionalinterest/pages/crc.aspx.
3. The African Charter on the Rights and Welfare of the Child adopted by the Organisation of African Unity in 1990 and came into force in 1999 available at https://www.un.org/en/africa/osaa/pdf/au/afr_charter_rights_welfare_child_africa_1990.pdf.
4. 2008 (3) SA 232 (CC).
5. Ibid at para 18.
6. Section 28(1)(b) –(d).
7. Section 28(2).
8. 2014 (2) SA 168 (CC).
9. Ibid at para 69.
10. South Africa's National Strategic Plan for HIV, TB and STI 2017-2022 available at https://sanac.org.za//wp-content/uploads/2017/06/NSP_FullDocument_FINAL.pdf.
11. Ibid at 7.

The Children's Act 38 of 2005 was enacted in order to give effect to Section 28 of the Constitution. It sets out principles relating to the care and protection of children in line with the CRC and African Charter on the Rights and Welfare of the Child. Section 11(3) of the Children's Act provides that a child with a disability or chronic illness has the right not to be subjected to medical, social, cultural or religious practices that are detrimental to his/her health, wellbeing or dignity.[12] In addition, the Children's Act recognises the best interests of the child[13] which is entrenched in Section 28(2) of the Constitution.[14]

2. Access to Healthcare for Children

2.1. Health and Medical Rights

Section 28 (1)(c) of the Constitution provides that '[e]very child has a right to basic nutrition, shelter, basic healthcare services and social services' and section 27(1)(a) provides that '[e]veryone has the right to have access to healthcare services including reproductive healthcare.' In addition, section 12(2)(a) of the Constitution provides that '[e]veryone has the right 'to make decisions concerning reproduction'.[15] These provisions are in line with article 24(1) of the CRC, which requires State parties to recognise 'the right of the child to the enjoyment of the highest attainable standard of health and facilities for the treatment of illness and rehabilitation of health' and with article 14(1) of the African Charter, which states that every child has 'the right to enjoy the best attainable state of physical, mental and spiritual health'. The Constitution accordingly recognises the right of children to access healthcare services, including reproductive healthcare services.

2.2. Free Healthcare

A framework for the protection, respect, and promotion of the right to health contained in the Constitution is found in the National Health Act 61 of 2003 (NHA). Section 4 of the NHA provides for free health services to be offered at public primary healthcare clinics and community healthcare centres. The NHA recognises the particular needs of vulnerable groups such as woman and children.[16] The National Health Act further provides that children below the age of six who are not members or beneficiaries of medical aid schemes are entitled to free healthcare services.[17]

3. Children and HIV

South Africa's current regulatory regime permits children to consent to HIV testing, medical treatment, surgical treatment and to access contraception at various points, based on age and capacity, before the age of 18.

3.1. HIV Testing, Privacy and Confidentiality

3.1.1. HIV Testing

A child may undergo an HIV test having undergone proper counselling by an appropriately trained person before and after the test. Counselling must be provided to the child if the child 'is of sufficient maturity to understand the benefits, risks and social implications' of the test and to the child's parent or care-giver 'if the parent or care-giver has knowledge of the test'.[18]

Section 130(1) and (2) of the Children's Act provides as follows:

'(1) No child may be tested for HIV except when –

(a) it is in the best interests of the child and consent has been given . . .; or

(b) the test is necessary in order to establish whether –

(i) a health worker may have contracted HIV due to contact in the course of a medical procedure involving contact with any substance from the child's body that may transmit HIV; or

(ii) any other person may have contracted HIV due to contact with any substance from the child's body that may transmit HIV, provided the test has been authorised by a court.

12. Section 11(3) of the Children's Act.

13. Section 7 and Section 9

14. Section 28(2) of the Constitution provides that 'a child's best interests are of paramount importance in every matter concerning the child.'

15. Section 12(2)*(a)* of the Constitution.

16 Section 2(c)(iv) of the National Health Act.

17. Section 4(3) of the National Health Act.

18. Section 132 of the Children's Act.

(2) Consent for an HIV-test on a child may be given by –

(a) The child, if the child is –

(i) 12 years of age or older; or

(ii) Under the age of 12 years and is of sufficient maturity to understand the benefits, risks and social implications of such a test;

(b) the parent or care-giver, if the child is under the age of 12 years and is not of sufficient maturity to understand the benefits, risks and social implications of such a test;

(c) the provincial head of social development, if the child is under the age of 12 years and is not of sufficient maturity to understand the benefits, risks and social implications of such a test;

(d) a designated child protection organisation arranging the placement of the child, if the child is under the age of 12 years and is not of sufficient maturity to understand the benefits, risks and social implications of such a test;

(e) the superintendent or person in charge of a hospital, if –

(i) the child is under the age of 12 years and is not of sufficient maturity to understand the benefits, risks and social implications of such a test; and

(ii) the child has no parent or care-giver and there is no designated child protection organisation arranging the placement of the child; or

(f) a children's court, if –

(i) Consent. . . is unreasonably withheld; or

(ii) the child or the parent or care-giver of the child is incapable of giving consent.'

3.1.2. HIV Testing for the Purpose of Adoption

There is no legal requirement that children undergo HIV testing for the purposes of adoption or foster care, but some adoption agencies will disclose the HIV status of children to prospective parents. Similarly, although there is no legal requirement that prospective parents or care-givers be tested for HIV, some adoption agencies will not allow persons with HIV to adopt and may demand that the applicants, child and birth mother be tested for HIV before they will proceed with a placement.[19] When a child is tested for foster care or adoption purposes, the State must bear the costs of the HIV test.[20]

3.1.3. The Right to Privacy

The Constitution provides that 'everyone has the right to privacy, which includes the right not to have the privacy of their communications infringed'[21] and the right to 'inherent dignity and the right to have their dignity respected and protected'.[22] These provisions are in line with article 16 of the CRC and article 10 of the African Charter.[23]

3.1.4. Disclosure of HIV Status

As regards disclosure of a child's HIV status, section 133 of the Children's Act provides as follows:

'(1) No person may disclose the fact that a child is HIV-positive without consent given in terms of subsection (2), except –

(a) within the scope of that person's powers and duties in terms of this Act or any other law;

(b) when necessary for the purpose of carrying out the provisions of this Act;

(c) for the purpose of legal proceedings; or

(d) in terms of a court order.

(2) Consent...may be given by –

(a) The child, if the child is –

(i) 12 years of age or older; or

(ii) under the age of 12 years and is of sufficient maturity to understand the benefits, risks and social implications of such a disclosure;

19. AIDS Law Project and AIDS Legal Network *HIV/AIDS and the Law: A Resource Manual* 3ed (2003), available at http://section27.org.za/2003/06/hivaids-and-the-law-manual at 258.

20. Section 131 of the Children's Act.

21. Section 14*(d)* of the Constitution.

22. Section 10 of the Constitution.

23. Article 16(1) of the CRC provides that –
'[n]o child shall be subjected to arbitrary or unlawful interference with his or her privacy, family, or correspondence, nor to unlawful attacks on his or her honour and reputation'.
Article 10 of the African Charter provides that –
'[n]o child shall be subject to arbitrary or unlawful interference with his privacy, family home or correspondence, or to the attacks upon his honour or reputation, provided that parents or legal guardians shall have the right to exercise reasonable supervision over the conduct of their children. The child has the right to the protection of the law against such interference or attacks.'

(b) the parent or care-giver, if the child is under the age of 12 years and is not of sufficient maturity to understand the benefits, risks and social implications of such a disclosure;

(c) a designated child protection organisation arranging the placement of the child, if the child is under the age of 12 years and is not of sufficient maturity to understand the benefits, risks and social implications of such a disclosure;

(d) The superintendent or person in charge of a hospital, if –

(i) the child is under the age of 12 years and is not of sufficient maturity to understand the benefits, risks and social implications of such a disclosure; and

(ii) the child has no parent or care-giver and there is no designated child protection organisation arranging the placement of the child; or

(e) A children's court, if –

(i) consent...is unreasonably withheld and disclosure is in the best interests of the child; or

(ii) the child or the parent or care-giver of the child is incapable of giving consent.'

Disclosure of the HIV status of a child that is not permitted by law is an offence that may on conviction give rise to a fine or imprisonment for a period of up to 10 years or to both a fine and imprisonment.[24] Should a child's HIV status be revealed without that child's consent, additional legal recourse includes suing the person who made the disclosure for civil damages and, if the disclosure was made by a healthcare worker, laying a complaint against that worker with the appropriate professional body such as the Health Professions Council of South Africa or the South African Nursing Council.

See detailed discussion on privacy and disclosure of a person's HIV and TB status without consent in Chapter 3.

3.2. Medical Treatment for Children

Section 129(2) and (4) of the Children's Act provides that –

'(2) A child may consent to his or her own medical treatment or to the medical treatment of his or her child if –

(a) The child is over the age of 12 years; and

(b) The child is of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the treatment.

(4) The parent, guardian or care-giver of a child may . . . consent to the medical treatment of the child if the child is –

(a) under the age of 12 years; or

(b) over that age but is of insufficient maturity or is unable to understand the benefits, risks and social implications of the treatment.'

Before a parent, guardian or care-giver makes such a decision, he or she must 'give due consideration to any views and wishes expressed by the child, bearing in mind the child's age, maturity and stage of development', and to 'any views and wishes expressed by any co-holder of parental responsibilities and rights in respect of the child'.[25] Other persons who may consent to the medical treatment of a child include:

- The superintendent of a hospital, or, in the absence of the superintendent, the person in charge of the hospital, if –
  (a) the treatment or operation is necessary to preserve the life of the child or to save the child from serious or lasting physical injury or disability; and
  (b) the need for the treatment or operation is so urgent that it cannot be deferred for the purpose of obtaining consent that would otherwise have been required.[26]
- The Minister for Social Development, if the parent or guardian
  (a) unreasonably refuses to give consent or to assist the child in giving consent;
  (b) is incapable of giving consent or of assisting the child in giving consent;
  (c) cannot readily be traced; or
  (d) is deceased.[27]

24. Section 305(1)(b) read with section 305(6) of the Children's Act.

25. Section 31(1)*(a)* and (2)*(a)* of the Children's Act.

26. Section 129(6) of the Children's Act.

27. Section 129(7) of the Children's Act.

In the event that the child unreasonably refuses to give consent[28] the High Court or Children's Court, 'where another person that may give consent . . . refuses or is unable to give such consent'.[29]

In *Ex parte Nigel Redman NO*,[30] Section 27 (Incorporating the AIDS Law Project) brought an urgent application to the High Court, seeking consent for four HIV-positive children to receive anti-retroviral drug treatment on behalf of the Wits Paediatric Working Group. All four children were orphans below the age of 14,[31] living in informal care settings, who had not been placed in the legal custody of their care-givers. Accordingly, it was not possible to obtain consent for the medical treatment of the children under the common law. The court recognised that the common-law rules pertaining to parental consent posed a significant hurdle to the children's timely access to necessary, life-prolonging medical treatment and accordingly authorised treatment in its capacity as upper guardian of all minors in South Africa, notwithstanding the lack of parental consent, on the understanding that the children's *de facto* care-givers consented to the treatment. The organisation Section 27 brought a second, similar application for consent, which was also successful, in *Ex parte Meyers*.[32]

On 20 August 2012, a Circular Minute No. 2 of 2012[33] was circulated by the South African Department of Health, informing all hospital heads that 'all HIV positive children aged 5 and under should be initiated on anti-retroviral treatment regardless of CD4 count and/or WHO Clinical Staging'. The National Consolidated Guidelines for the Prevention of Mother-to-Child Transmission of HIV (PMTCT) and the Management of HIV in Children, Adolescents and Adults provides for specific treatment guidelines for infants.[34]

4. Sexual and Reproductive Health Rights for Adolescents

4.1. Introduction

In *Teddy Bear Clinic for Abused Children and RAPCAN v Minister of Justice and Constitutional Development and Another (Teddy Bear Clinic)*[35] the constitutionality of sections 15 and 16 of the Criminal Law (Sexual Offences and Related Matters) Amendment Act[36] were challenged. These provisions made it a sexual offence for children aged 12 – 16 to engage in consensual sexual activities (ranging from kissing to penetration). It also obliged adults to report a known sexual offence to the police – even if those involved are consenting adolescents. It was argued that these provisions did not serve the best interest of the children and that the criminalisation of consensual teenage sexual activity and the consequent reporting to the police violated the constitutional right to dignity, bodily and psychological integrity, and privacy.[37] The Constitutional Court found the provisions to be unconstitutional. It was noted by the Court that both parties agree that '[t]he use of damaging and draconian criminal law offences to attempt to persuade adolescents to behave responsibly is a disproportionate and ineffective method which is not suited to its purpose'.[38]

28. Section 129(8) of the Children's Act.

29. Section 129(9) of the Children's Act.

30. Unreported WLD case, no. 14083/03.

31. In terms of section 39 of the repealed Child Care Act 74 of 1983, children could consent to medical treatment from the age of 14. Children below the age of 14 required the consent of a parent or legal guardian. If consent could not be obtained from a parent or legal guardian a social worker had to send a report to the relevant provincial department of social development for consent or the court had to be approached for consent.

32. Unreported WLD case, no. 29172/03.

33 'Circular Minute 2 of 2012: Initiation of antiretroviral treatment to all HIV positive children aged 5 years and under regardless of CD4 count and/or WHO clinical staging' (2012), available at http://www.sahivsoc.org/upload/documents/Rx%20of%20children%20under%205-Circular%20Minute%20No%202%20of%202012%20-%20ART.pdf.

34. http://www.health.gov.za/index.php/2014-03-17-09-09-38/policies-and-guidelines/category/230-2015p. See Chap. 3 above for more details on ARV treatment.

35. 2014 (2) SA 168 (CC).

36. 32 of 2007.

37. Paula Proudlock et al "Legislative and policy developments 2012/2013: Children and Law Reform" Equal Education Law Centre – South Africa Child Gauge available at http://www.ci.uct.ac.za/sites/default/files/image_tool/images/367/Child_Gauge/South_African_Child_Gauge_2013/Gauge2013LegiDevelopments.pdf last accessed on 23 March 2020.

38. *Teddy Bear Clinic* above n44 at para 52.

The Court further noted that the duty to report sexually active adolescents limits the ability of adults to provide education, guidance and support to children in their sexual development.[39]

The case led to the revision of the Sexual Offences Act which provides that the age of consent to sex in South Africa is 16 years. The Sexual Offences Act now provides that adolescents aged 12 - 15 years old may engage in consensual sex with peers in the same age category without criminal sanction. Adolescents aged 12-15 may also have sex with 16-17-year-olds, provided that there is no more than a 2-year age gap between them.[40]

Importantly, the Constitutional Court found that sexual activity and exploration is part of normative development from adolescence to adulthood. 'Adolescents' right to engage in sexual intercourse, and the imperative to address potential legal barriers to accessing sexual and reproductive health services, is set within the context of their many health risks'.[41] Adolescents are largely at risk of being infected with HIV, STIs and pregnancy owing to high-risk sexual behaviour, physical, social and structural challenges.[42]

In 2013, Statistics SA reported that 99 000 school-going adolescent girls were pregnant.[43] The most recent National HIV Prevalence, Incidence and Behaviour Survey[44] found an HIV prevalence of 7.1% for youth aged 12-24 years. The HIV incidence among young women 15-24 years old shows 113 000 new infections annually, four times higher than that of their male peers.[45]

South Africa has progressive legislation that enables adolescents to access various sexual and reproductive health ('SRH') services independently, without consent from their parents or legal guardians. The following are four SRH services that adolescents have the right to access:

- Contraceptives: Age of consent is 12 years;
- Termination of pregnancy: No specified age of consent;
- Sterilisation: Age of consent is 18 years; and
- Male circumcision: Age of consent is 16 years.

4.2. Access to Contraceptives

In terms of section 134(1) of the Children's Act, children over the age of 12 are entitled to purchase condoms and to be provided with condoms on request 'where such condoms are provided or distributed free of charge'.[46] Contraceptives other than condoms may also be provided to a child on request by the child and without the consent of the parent or care-giver of the child if –

(a) the child is at least 12 years of age;

(b) proper medical advice is given to the child; and

(c) a medical examination is carried out on the child to determine whether there are any medical reasons why a specific contraceptive should not be provided to the child.

(d) in terms of the Children's Act, a child who obtains condoms, contraceptives or contraceptive advice in is entitled to confidentiality in this respect, subject to section 110.[47]

39. Ibid at para 98-9.

40. A Strode and Z Essack "Facilitating access to adolescent sexual and reproductive health services through legislative reform: Lessons from the South African experience" (2017) 107(9) *Southern African Medical Journal* available at http://www.scielo.org.za/pdf/samj/v107n9/13.pdf last accessed on 13 March 2020

41. Ibid at 741

42. Ibid.

43. Statistics South Africa 'Statistical Release P0302: Mid-year population estimates 2013', available at http://www.statssa.gov.za/publications/P0302/P03022014.pdf. last accessed 26 March 2020.

44 National HIV Prevalence, Incidence and Behaviour and Communication Survey, 2017 available at https://tbsouthafrica.org.za/sites/default/files/201910%20South%20African%20National%20HIV%20Prevalence%2C%20Incidence%2C%20Behaviour%20and%20Communications%20Survey%202017.pdf. Last accessed on 3 Novemeber 2020.

45. Shisana O, Rehle T, Simbayi LC, et al. South African National HIV Prevalence, Incidence and Behaviour Survey, 2012. Cape Town: HSRC Press, 2014. See also Simbayi LC, Zuma K, Zungu N, Moyo S, Marinda E, Jooste S, Mabaso M, Ramlagan S, North A, van Zyl J, Mohlabane N, Dietrich C, Naidoo I and the SABSSM V Team (2019) *South African National HIV Prevalence, Incidence, Behaviour and Communication Survey*, 2017. Cape Town: HSRC Press at 4.

46. Section 134(1) of the Children's Act.

47. Section 134(2) and (3) of the Children's Act.

In terms of section 110, health professionals are required to report cases of physical or sexual abuse or deliberate neglect of a child to the Department of Social Development, a designated child protection organisation or the police.

The National Contraception and Fertility Planning Policy and Service Delivery Guidelines recognises[48] that the objective of section 134 of the Children's Act is to 'prevent sexually active children from contracting sexually transmitted infections (including HIV) or falling pregnant'.[49] This is a critical part of child protection.[50]

Department of Health has explicitly recognised these risks in its 2012 Contraception Policy and therefore advises health professionals to enable adolescents to have access to counselling, contraception and healthcare services rather than follow a rigid approach to the reporting obligations:

> *'The overarching public health imperative to prevent teenage pregnancy and prevent HIV and STIs needs to guide the provision of quality health services for young people. Every effort should therefore be made to provide accessible sexual and reproductive health services that take into account young people's vulnerability, psychosocial needs and their right to confidentiality. All initiatives should focus on prevention and, where this fails, to provide safe, quality youth-friendly services. This needs to be the overriding ethos, and should be counter-balanced with the rigid implementation of the reporting obligations.'*[51]

4.3. Access to Termination of Pregnancy Services

Even though termination of pregnancy is a medical treatment or surgical operation, section 129 of the Children's Act does not apply to it.[52] The Choice on Termination of Pregnancy Act[53] provides that a 'woman of any age can consent to a termination of her pregnancy and only her consent is required'.[54] When the person who wants to undergo a termination of pregnancy is under the age of 18, the doctor or midwife must advise her to speak to her parents or other family members before she undergoes the procedure, but she does not have to follow this advice and does not need the consent of her parents or family.[55]

4.4. Access to Safe Male Circumcision Services

Voluntary medical male circumcision can significantly reduce the risk of HIV transmission.[56] This is one of the evidence-based interventions that has been implemented aggressively in South Africa as part of a combination HIV-prevention package for males since 2010.[57] Although male circumcision is offered in public hospitals, every year, boys in various parts of the country attend traditional initiation schools to undergo this procedure, which is viewed as an important rite of passage into manhood.[58] The process has not been without flaws as there have been a number of initiates requiring hospitalisation from a botched circumcision. Hospitalisation of initiates is often linked to the following factors:

48. Department of Health 'National Contraception and Fertility Planning Policy and Service Delivery Guidelines: A companion to the National Contraception Clinical Guidelines' (2012), available at http://www.health-e.org.za/wp-content/uploads/2014/05/National-contraception-family-planning-policy.pdf. last accessed on 17 April 2020
49. Clause 6.1.1 of the National Contraception and Fertility Planning Policy and Service Delivery Guidelines
50. Jamieson and Lake *Children's Act Guide for Health Professionals* 5th ed (Cape Town: Children's Institute, University of Cape Town, 2013) at 16.
51. Department of Health "National Contraception and Fertility Planning Policy and Service Delivery Guidelines" 2012 at 44.
52. Section 129(1) of the Children's Act provides that 'subject to section 5(2) of the Choice on Termination of Pregnanacy Act, a child may be subjected to medical treatment or a surgical operation only if consent for such treatment or operation has been given.'
53. 92 of 1996.
54. Section 5(2) read with section 1 of the Choice on Termination of Pregnancy Act.
55. Section 5(3) of the Choice on Termination of Pregnancy Act.
56. HSRC Report 2019 above n 66 at 75
57. Ibid
58. Anele Khumalo " Balancing culture, religion and health care: The legal framework for male circumcision" International Law Office (14 May 2014) available at https://www.werksmans.com/wp-content/uploads/2014/06/The-Legal-Framework-for-Male-Circumcision.pdf. last accessed on 17 April 2020.

a. poor accessibility and construction of the facilities where the initiation takes place;
b. poor wound care;
c. delays in seeking medical treatment; and the procedures being performed by untrained and unskilled persons and, in certain instances, by persons who have just undergone the initiation process.[59] The reports around the death of initiates circumcised for cultural reasons in environments that are unhygienic, poses a danger to the health of the initiates and is counterproductive to this intervention.

The Children's Act has a significant level of legal protection against unwanted or unsafe circumcision. It gives children the right not to be subjected to social, cultural and religious practices detrimental to their well-being, and prohibits circumcision of male children under the age of sixteen except in cases where there is a valid religious reason, or if the operation is medically necessary for therapeutic purposes. Section 12(1), (8) – (10) of the Children's Act provides that –

'(1) Every child has the right not to be subjected to social, cultural and religious practices which are detrimental to his or her well-being.

(8) Circumcision of male children under the age of 16 is prohibited, except when –
  (a) circumcision is performed for religious purposes in accordance with the practices of the religion concerned and in the manner prescribed; or
  (b) circumcision is performed for medical reasons on the recommendation of a medical practitioner.

(9) Circumcision of male children older than 16 may only be performed –
  (a) if the child has given consent to the circumcision in the prescribed manner;
  (b) after proper counselling of the child; and
  (c) in the manner prescribed.

(10) Taking into consideration the child's age, maturity and stage of development, every male child has the right to refuse circumcision

Section 12(8) of the Children's Act accordingly prohibits the circumcision of boys under the age of 16, except when the circumcision is performed for religious purposes in accordance with the practices of the child's religion and in the manner prescribed by the religion concerned, or 'for medical reasons on the recommendation of a medical practitioner'. Section 12(9) of the act provides that boys older than 16 may be circumcised only if the child has consented to the circumcision in the manner prescribed in the regulations promulgated under the Act and after the child has undergone proper counselling, taking into account the child's age, maturity and stage of development, every boy has the right to refuse circumcision.

Section 5 and 6 of the General Regulations Regarding Children, published under Section 306 of the Children's Act,[60] provide details of the requirements that must be met in order for a circumcision for cultural or religious purposes to be performed.

5. Children Orphaned by HIV and TB

5.1. The Right to Care

Section 28(1)(b) of the Constitution provides that every child has the right 'to family care or parental care, or to appropriate alternative care when [he or she] is removed from the family environment'. [61]In *Government of the Republic of South Africa v Grootboom*,[62] the Constitutional Court held that section 28(1)(b) 'contemplates that a child has the right to parental or family care in the first place' and the right to alternative appropriate care provided by the State only when the former is lacking.[63]

59. Ibid

60. As published in Government Gazette No. 33076 of 1 April 2010 available at https://www.justice.gov.za/legislation/notices/2010/20100401_GG33076_NoticeR261-childrensact-reg.pdf. last accessed on 3 November 2020.

61. The CRC recognises that there is a broad range of persons who can take responsibility for a child. In particular, article 5 requires state parties to 'respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family or community as provided for by local custom, legal guardians or other persons legally responsible for the child, to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the Convention'.

62. 2001 (1) SA 46 (CC).

63. Ibid at para 77.

5.2. Care and Protection

Section 150(1) of the Children's Act identifies specific examples of when a child is in need of care and protection which include circumstances where the child –

(a) has been abandoned or orphaned and is without any visible means of support;[64]

...

(h) is in a state of physical or mental neglect;[65] or

(i) is being maltreated, abused, deliberately neglected or degraded by a parent; a care-giver, a person who has parental responsibilities and rights or a family member of the child or by a person under whose control the child is.[66]

In terms of section 150(2) of the Children's Act, a child who is the victim of child labour or in a child-headed household may be in need of care and protection and the matter must be referred to a social worker for investigation.[67] If the social worker finds that the child is not in need of care and protection, he or she must, where necessary, 'take measures to assist the child, including counselling, mediation, prevention and early intervention services, family reconstruction and rehabilitation, behaviour modification, problem solving and referral to another suitably qualified person or organisation'.[68] A social worker or police officer may, under certain circumstances, remove a child and place him or her in temporary safe care without a court order.[69]

In other instances, if a social worker finds that a child is in need of care and protection, the child must be brought before a Children's court for a final decision on whether the child is in need of care and protection.[70] The court may:

'*(b)* Order that, pending decision of the matter, the child must –

(i) remain in temporary safe care at the place where the child is kept;

(ii) be transferred to another place in temporary safe care;

(iii) remain with the person under whose control the child is;

(iv) be put under the control of a family member or other relative of the child; or

(v) be placed in temporary safe care.'[71]

If the court finds that the child is in need of care and protection, it may make an appropriate order that is in the best interests of the child.[72]

It should be noted that the 'removal of a child from his or her present living environment to new accommodation (alternative care) should always be treated as a measure of last resort'.[73] Children may be removed from their present living conditions only when removal is necessary for their safety and well-being.[74] In this regard, a child in a home with a parent or care-giver living with HIV is not

64. For example, when the parents or care-givers have died of HIV/AIDS and the child has no parents or when a child is living with HIV/AIDS and the parents are not able to care properly for the child's health needs or have abandoned the child.

65. For example, when the parents or care-givers have died of HIV/AIDS and there is no one to take care of the child or the child is ill-treated by the parents or care-givers because the child has HIV/AIDS.

66. For example, when a child is being treated badly by a parent or care-giver because he or she has HIV/AIDS.

67 Section 150(2)(b) of the Children's Act. Examples of child-headed households include those in which the parent or care-giver has HIV/AIDS and is unable to take proper care of the child, or the child takes on the role of a care-giver and has to leave school early to take care of the ill parent or care-giver or earn money to support the family.

68. Section 150(3) of the Children's Act.

69. Section 152(1) of the Children's Act provides that a designated social worker or police officer may remove a child if there are reasonable grounds to believe –
'(a) that the child –
(i) is in need of care and protection; and
(ii) needs immediate emergency protection;
(b) that the delay in obtaining a court order for the removal of the child and placing the child in temporary safe care may jeopardise the child's safety and well-being; and
(c) that the removal of the child from his or her home environment is the best way to secure that child's safety and well-being.'

70. Section 155(5) of the Children's Act.

71. Section 155(6)(b) of the Children's Act.

72. Section 156(1) of the Children's Act.

73. Matthias and Zaal 'The child in need of care and protection' in Boezaart (ed) *Child Law in South Africa* (Cape Town: Juta, 2009) at 168. See also section 156(1)(e) of the Children's Act.

74. Section 151(2) of the Children's Act.

necessarily in need of care and protection and does not automatically need to be placed in alternative care.[75]

5.3. Placing Children in Need of Care and Protection

5.3.1. Supervision

When the Children's Court decides that a child is in need of care but does not need to be removed from the parents or care-giver it may decide to leave the child in the care of the parents or care-giver under the supervision of a social worker who will check that the child is being given enough care.[76] If the parent or care giver does not care for the child or meet the conditions set by the court, the child may be removed from him or her.

5.3.2. Alternative Care

The court may decide to place a child in alternative care for a limited period with a view to reuniting the child with the parent or care-giver with the assistance of a designated social worker, with or without terminating the rights and responsibilities of the parent or care-giver.[77] Alternative care includes foster care, care in a youth care centre, and temporary safe care.[78] 'A child may not be in temporary safe care or be kept or retained at any place or facility, including a registered child and youth care centre, for longer than six months without a court order placing the child in alternative care.'[79]

In *SS v Presiding Officer of the Children's Court: District of Krugersdorp and others*[80] the court considered whether an orphaned child,SS, living with relatives could be placed in foster care (a form of alternative care) with those relatives. The child had lived with his mother (Ms Stemele) and grandmother in the Eastern Cape since his birth in 2000. After his grandmother died in 2002, SS was left in the care of the Lamanis. Ms Stemele also deposed to an affidavit to enable Ms Lamani to receive a child support grant for the child. Ms Stemele visited SS from time to time but became ill and died in 2007. 'She was never legally married and did not appoint a guardian to the minor child in the event of her death, nor did she disclose who the father of the minor child was, nor did anyone acknowledge paternity.'[81]

The Centre for Child Law brought an application for a foster-care order on behalf of the minor child in the District of Krugersdorp. The Commissioner concluded that the child was not in need of care as envisioned in section 155(1) of the Children's Act and refused to place the child in foster care. On appeal, the High Court held that '[a] child who has been orphaned or abandoned, and who is living with a caregiver who does not have a common-law duty of support towards such child, may be placed in foster care with that caregiver'.[82] The High Court upheld the appeal and found SS to be in need of care and protection and placed him in foster care with the Lamanis.

5.3.3. Adoption

The court may decide to make the child available for adoption including inter-country adoption.[83] 'Adoption is when people (or a single person) agree to permanently take care of a child who is not their own. The law then treats the child as the child of the new parent or parents. The adoptive parent/s...become the child's legal guardian/s.'[84]

5.3.4. Partial Care

The Children's court may decide to put a child in partial care. The types of partial care envisioned by the Children's Act include early childhood development

75. HIV/AIDS and the Law Manual above n 26 at 253.

76. Section 157(1)(b)(i) of the Children's Act.

77. Section 157(1)(b)(ii) and (iii) of the Children's Act.

78. Section 167(1) of the Children's Act.

79. Sections 155(5) and 167(2) of the Children's Act.

80. 2012 (6) SA 45 (GSJ).

81. Ibid at para 8.

82. Ibid at para 29.

83. In *Minister of Welfare and Population Development v Fitzpatrick and others* 2000 (3) SA 422 (CC), the Constitutional Court held that section 18(4)(f) of the Child Care Act 74 of 1983 which prohibited the adoption by non-South-African citizens of children born in South Africa was unconstitutional. The court suspended the order of invalidity for a period of two years to enable Parliament to correct the defect in the legislation. The Child Care Act was subsequently repealed by the Children's Act. Inter-country adoptions are now dealt with in Chapter 16 of the Children's Act.

84. HIV/AIDS and the Law Manual above n26 at 256.

services to promote early childhood development, which are provided by a person other than the child's parent or care-giver on a regular basis to children up to school going age (for example, crèches and nursery schools);[85] after-school services, other than services provided by a primary or secondary school for children attending that school;[86] private hostels;[87] and 'temporary respite care services for children including children with disabilities'.[88]

5.3.5. Prevention and Early Intervention

Prevention and early intervention programmes may be provided 'to families with children in order to strengthen and build their capacity and self-reliance to address problems that may or are bound to occur in the family environment which, if not attended to, may lead to statutory intervention'.[89] These programmes must focus on –

a. preserving a child's family structure;
b. developing appropriate parenting skills and the capacity of parents and care-givers to safeguard the well being and best interests of their children, including the promotion of positive, non-violent forms of discipline;
c. developing appropriate parenting skills and the capacity of parents and care-givers to safeguard the well being and best interests of children with disabilities and chronic illnesses;
d. promoting appropriate interpersonal relationships within the family;
e. providing psychological, rehabilitation and therapeutic programmes for children;
f. preventing the neglect, exploitation, abuse or inadequate supervision of children and preventing other failures in the family environment to meet children's needs;
g. preventing the recurrence of problems in the family environment that may harm children or adversely affect their development;
h. diverting children away from the child and youth care system and the criminal justice system; and
i. avoiding the removal of a child from the family environment.[90]

5.3.6. Support for Children in Child-headed Households

A child-headed household is a household in which

a. the parent, guardian or care-giver... is terminally ill, has died or has abandoned the children...;
b. no adult family member available to care for the children...; or
c. a child over the age of 16 years has assumed the role of a care giver....[91]

Provincial heads of social development may recognise a household as a child-headed household in these circumstances or 'if it is in the best interest of the children in the household' to do so.[92] When such a provincial head identifies a child-headed household, the household must be placed under the general supervision of an adult designated by a Children's Court or of an organ of state or a non-governmental organisation determined by the provincial head of social development.[93] The supervising adult must perform the duties in relation to the household as prescribed and be a fit and proper person to supervise a child-headed household.[94]

5.3.7. Drop-in Centres

In terms of the Children's Act, a drop-in centre is a facility that provides 'basic services aimed at meeting

85. Regulation 12(1)(a) of the General Regulations regarding Children, 2010, published under GN R261 in *Government Gazette* 33076 of 1 April 2010, read with section 91(2) of the Children's Act.
86. Regulation 12(1)*(b)*.
87. Regulation 12(1)*(c)*.
88. Regulation 12(1)*(d)*.
89. Section 143(1)*(b)* of the Children's Act.
90. See sections 143–149 of the Children's Act read with regulation 52 of and Part IV of Annexure A to the General Regulations Regarding Children, 2010.
91. Section 137(1) of the Children's Act. See also 'Analysing the nature and extent of child-headed households in South Africa', available at http://www.ci.org.za/index.php?option=com_content&view=article&id=616:analysing-the-nature-and-extent-of-child-headed-households-in-south-africa&catid=37&Itemid=172.
92. Section 137(1) of the Children's Act.
93. Section 137(2) of the Children's Act.
94. Section 137(3) of the Children's Act.

the emotional, physical and social development needs of vulnerable children'.[95] Drop-in centres provide vulnerable children, such as children affected by HIV, access to basic services and support during the day. These services include feeding schemes, guidance and counselling, social skills and life skills, recreation, community services, primary healthcare, school attendance support, assistance with personal hygiene and laundry services. Traditionally, drop-in centres for children offer more than just basic services and can include outreach services and family preservation and reunification programmes.

6. Rights to Basic Education for Children Living with HIV

Section 29(1) (a) of the Constitution provides that everyone has the right to a 'basic education'. Furthermore, the CRC requires state parties to provide free 'primary education'.[96] Similarly, the African Charter requires state parties to provide free 'basic education'.[97] The right to basic education contained in the Constitution is immediately realisable.

The South African School Act[98] provides that schools must admit all learners and must not discriminate against any learner. Thus, a child may not be excluded from school because of his/her HIV status. This law applies to both public and government schools.

The National Policy on HIV/AIDS for Learners and Educators in Public Schools, and Students and Educators in further Education and Training Institutions,1999[99] sets out some important policy issues on children with HIV/AIDS in schools. The important principles in the National Policy on HIV/AIDS include the following:

a. Learners and students with HIV or AIDS should live as full a life as possible and should not be denied an opportunity to receive education that fits their ability.
b. No learner or educator can be forced to disclose his/her HIV status.
c. If anyone knows about the HIV status of a learner or educator, this information must be kept confidential.
d. No learner or educator may be asked to have an HIV test.
e. Learners and educators should not be discriminated against because of their HIV status.
f. If a learner becomes incapacitated through illness, the school must take steps to arrange home study for the learner.

In seeking to provide a safe environment for all learners, the National Policy on HIV/AIDS states that:

a. All open wounds, sores and breaks in the skin should be completely covered.
b. All learners should be taught not to touch any wounds, blood or sores.
c. No learner should play contact games or sports with an open wound, sore or break in skin.
d. If there is any bleeding during sport, the learner must be removed from the sport.

7. Children's Right to Sexual and Reproductive Education and Information

Sexual education includes teaching about safer sexual practices to prevent the spread of HIV. The inadequacy of and lack of information has been found to largely be based on beliefs that to do so will encourage children to engage in sexual activity prematurely.[100] Research, however, shows this to be untrue and that in fact 'when sex positive messages are given, children tend to engage in fewer high-risk behavior'.[101]

95. Section 213(1) of the Children's Act.
96. Article 28 of the CRC.
97. Article 11(3)(a) of the African Charter.
98. 84 of 1996.
99. Department of Education: National Education Policy Act 27 of 1996, Notice No 1926 of 1999; National Policy on HIV/AIDS, for Learners and Educators in Public Schools, and Students and Educators in Further Education and Training Institutions
100. Bankole and Malarche "Removing Barriers to Adolescents' Access to Contraceptive Information and Services" (2010) 41(2) *Studies in Family Planning* 119.
101. Macleod "Danger and Disease in Sex Education: The Saturation of 'Adolescence' with Colonialist Assumptions" (2009) 11 *Journal of Health Management* 380.

Children can only be taught about safer sex if they have an understanding of the following:

a. what sex is;
b. their physical anatomy (what their body parts are and how to use them);
c. how they can respond to feelings for another person; and
d. that they have the right to control of their own bodies.

As stated, South Africa signed the United Nations Convention on the Rights of the Child (CRC) in 1995. This means that South Africa agreed to implement the Articles in the CRC. Article 17 of the CRC[102] provides that a child should have access to information that will help the child to develop his/her physical and emotional well-being. Sexual education and information on HIV/AIDS will certainly help a child to develop his/her physical and emotional well-being. South Africa has thus agreed to ensure that children have to this type of education. The National Policy on HIV/AIDS also encourages teaching children about the prevention of HIV/AIDS through sex. This is due to the number of young people who are sexually active, thus sexual education will result in a lower rate of HIV transmission.

Section 13 of the Children's Act guarantees the right of every child to access information regarding their SRH and prevention of ill-health related thereto.[103] The information made available to children is further required to be relevant, accessible and in a child-friendly format.[104]

8. Legal Remedies Under the Children's Act

Section 42 of the Children's Act establishes the Children Court. The Children's court is specialised court which deals with issues affecting children. In *H v Fetal Assessment Centre*,[105] the Constitutional Court held the following:

'In South Africa, in addition to section 28(2) of the Constitution, the common law principle that the High Court is the upper guardian of children obliges courts to act in the best interest of the child in all matters involving the child. As upper guardian to all dependent and minor children, courts have a duty and authority to establish what is in the best interest of children. Notably in *Mpofu,*[106] this Court endorsed the approach in *Kotze v Kotze*:[107]

> 'The High Court sits as upper guardian in matters involving the best interests of the child (be it in custody matters or otherwise), and it has extremely wide powers in establishing what such best interest are.'[108]

The Children's court thus takes care of children in need of care and protection which includes making decisions about children who are abandoned, neglected or abused.

Any person can approach the clerk of the Children's court when he or she believes that a child is in need of care and protection. The Court can place a child in safe care or refer the child or the parent to services that they require.

102. Children's Charter of South Africa, 1992

103 Section 13 of the Children's Act is headed 'Information on health care' and provides as follows:
'(1) Every child has the right to—
(a) have access to information on health promotion and the prevention and treatment of ill-health and disease, sexuality and reproduction;
(b) have access to information regarding his or her health status;
(c) have access to information regarding the causes and treatment of his or her health status; and
(d) confidentiality regarding his or her health status and the health status of a parent, care-giver or family member, except when maintaining such confidentiality is not in the best interests of the child.
(2) Information provided to children in terms of this subsection must be relevant and must be in a format accessible to children, giving due consideration to the needs of disabled children.'

104. Section 13(1)(d) and 13(2) of the Children's Act.

105. 2015 (2) SA 193 (CC).

106. *Mpofu v Minister for Justice and Constitutional Development and Others* [2013] ZACC 15 at para 21.

107. 2003 (3) SA 628 (T) at 630G.

108. *H v Fetal Assessment Centre* at para 64.

SUB-CHAPTER 4.3: PRISONERS (INMATES)

1. Introduction

The incidence of Human Immunodeficiency Virus (HIV) and Tuberculosis (TB) in South African prisons is linked to systemic failings, which are fuelled by overcrowded and inhumane conditions and the excessive use of incarceration.[1] The rate of HIV and TB transmission is increased by incarceration and is correlated with unprotected sex and the injecting drugs in correctional facilities, but may also include blood exposure as a result of violence and other factors. It is therefore, critical to establish and maintain high-quality HIV and TB control programmes for inmates within the correctional system. South Africa's constitutional and legal framework protecting human rights in prisons is progressive. In addition, there is a need to implement policies and laws that ensure that inmates can live in a safe and healthy environment where they are not at risk of transmission of HIV, TB or sexually transmitted infections (STI's).[2]

2. The Right to Healthcare in Correctional Service Centres

2.1. Introduction

Before 1994, the law applicable to HIV and TB was derived from common law, which recognised inmates entitlement to medicine where the circumstances of their incarceration unnecessarily violated their natural rights.[3] Under the democratic dispensation and the new Constitution, incarcerated peoples' constitutional and legal rights are supported by the following 'statutes, policies, and regulations that provide minimum norms and standards for conditions in prisons and the treatment of people in prison':[4]

- The Constitution of the Republic of South Africa, 1996 which enshrines Constitutional rights of inmates.
- The Correctional Services Act[5] and its regulations, whose objective it is to give effect to the rights contained in the Constitution with regard to inmates.
- The White Paper on Corrections on Remand Detention Management in South Africa, 2014, which provides for rehabilitation as a core function of the prison system.
- South Africa's National Strategic Plan on HIV, TB and STIs 2017-2022, which identifies inmates as the group most vulnerable to HIV and a high risk group for TB, characterised by a 2.1% prevalence rate amongst inmates. The National Strategic Plan emphasises the need to adopt an approach that 'moves the country towards the epidemic's control'.[6]
- Department of Health Guidelines for the Management of TB, HIV and STIs in Correctional Facilities which provide standards which South African correctional authorities must strive to achieve in their effort to prevent HIV and TB transmission in correctional centres and to provide care to those most affected by these diseases.
- The National Policy to Address Sexual Abuse of Inmates in Correctional Facilities which introduces and addresses the problem of sexual violence in detention with the aim of to addressing sexual abuse of inmates in correctional facilities. It outlines how to prevent, detect, respond to and monitor sexual violence against inmates.

These documents have been used collectively to guide HIV and TB detection, control, treatment, and prevention in South African prisons.

2.2. Constitutional and Legislative Framework

Section 27(1) and (2) of the Constitution guarantees everyone's right to healthcare, food, water and social security. It also requires the state to take reasonable legislative measures, within its available resources, to

1. Keehn and Nevin "Health, Human rights and the transformation of punishment: South African Litigation to address HIV and Tuberculosis in Prisons" (2020) *Health and Human Rights Journal* at 2.
2. Matsoso, M. Department of Health: 'Guidelines for the Management of tuberculosis, human immunodeficiency virus and sexually transmitted infections in correctional centres' 2013 at VIII.
3. Motala "Do inmates in South Africa have a constitutional right to a holistic approach to antiretroviral treatment?" *South African Journal of Bioethics and Law* available at http://www.sajbl.org.za/index.php/sajbl/article/view/290/311. last accessed on 7 April 2020.
4. Ibid at 2
5. 111 of 1998.
6. South Africa's National Strategic Plan on HIV, TB and STIs 2017-2022 at 4.

achieve the progressive realisation of these rights.[7]

Section 35 of the Constitution provides that 'arrested, detained and accused persons' are entitled 'to conditions of detention that are consistent with human dignity, including exercise and the provision, at state expense, of adequate accommodation, nutrition, reading material and medical treatment'.[8]

Section 12(1) to 12(4) of the Correctional Services Act[9] gives effect to Section 35 of the Constitution by providing that:

'(1) The Department must provide, within its available resources, adequate healthcare services, based on the principles of primary healthcare, in order to allow every inmate to lead a healthy life.

(2) (a) Every inmate has the right to adequate medical treatment but no inmate is entitled to cosmetic medical treatment at State expense.

(b) Medical treatment must be provided by a medical officer, medical practitioner or by a specialist or healthcare institution or person or institution identified by such medical officer, except where the medical treatment is provided by a medical practitioner in terms of subsection.

(3) Every inmate may be visited and examined by a medical practitioner of his or her choice and, subject to the permission of the Head of Prison, may be treated by such practitioner, in-which event the inmate is personally liable for the costs of any such consultation including examination, service or treatment.

(4) (a) Every inmate should be encouraged to undergo medical treatment necessary for the maintenance or recovery of his or her health.

(b) No inmate may be compelled to undergo medical examination, intervention or treatment 'without informed' consent unless failure to submit to such medical examination, intervention or treatment will pose a threat to the health of other persons.

(c) Except as provided in paragraph (d), no surgery maybe performed on an inmate without his or her informed consent, or, in the case of a minor, with the written consent of his or her legal guardian.

(d) Consent to surgery is not required if, in the opinion of the medical practitioner who is treating the inmate, the intervention is in the interests of the inmate's health and the inmate is unable to give such consent, or, in the case of a minor, if it is not possible or practical to delay it in order to obtain the consent of his or her legal guardian.'

The Department of Correctional Services (DCS) has the mandate to facilitate inmates' access to healthcare within its available resources and the standard of the treatment must be in line with the principles of primary healthcare in order to ensure that inmates get adequate healthcare.[10]

To give effect to this mandate, the DCS is guided by a Strategic Plan. The DCS Strategic Plan 2015/2016-2019/2020 recommends needs – based healthcare programmes and services aimed at maintaining the wellbeing of inmates in the Department of Correctional Services' custody.[11] The strategic objectives of the DCS Strategic Plan are to:

- provide inmates with HIV and TB services to improve life expectancy;
- provide inmates with appropriate nutritional services; and
- provide inmates with appropriate hygiene services during their period of incarceration.[12]

7. Section 27(2) of the Constitution. Section 27 is headed 'health care, food, water and social security'. Section 27(1) provides as follows:
   (1) Everyone has the right to have access to –
   (a) health care services, including reproductive health care;
8. Section 35(2)(e) of the Constitution.
9. 111 of 1998.
10. The Correctional Services Act 111 of 1998.
    (1) The Department must provide, within its available resources, adequate health care services, based on the principles of primary health care, in order to allow every inmate to lead a healthy life.
    (2)(a) Every Inmate has the right to adequate medical treatment but no inmate is entitled to cosmetic medical treatment at State expense.
11. Department of Correctional Services: "Strategic Plan for 2015/2016- 2019/2020" at 44.
12. Ibid.

In terms of the DCS Strategic Plan, the DCS is required to provide 24 hour healthcare services to inmates which are inclusive of promotive, preventative, curative and rehabilitative care for acute minor ailments, injuries, communicable diseases such as TB, HIV and STIs and non-communicable diseases such as diabetes, epilepsy and hypertension.

2.3. International Human Rights Framework for Inmates

The preamble of the Correctional Services Act provides for the changing of law governing correctional system by recognising international principles on correctional matters. This means that the Constitution incorporates and makes justiciable international human rights laws that protect inmates' rights.[13]

The Universal Declaration on Human Rights (UDHR),[14] the International Covenant on Civil and Political Rights (ICCPR)[15] and the International Covenant on Social, Economic and Cultural Rights (ICESCR)[16] forms a package referred to as the International Bill of Rights and contains provisions applicable to inmates.

The UDHR provides that 'Everyone has the right to a standard of living adequate for the health and wellbeing of himself', and this includes 'medical care.'[17] The ICCPR states that every person has the inherent right to life. The Human Rights Committee has explained that this right must be interpreted broadly and that governments must adopt positive, proactive measures to protect human life, including measures that can reduce the spread of epidemics.[18]

The ICSEC recognises 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'.[19] Even though South Africa has not yet ratified this convention, by signing the treaty it indicated its intention to ratify it and incurred an international obligation not to act contrary to the ICESR's object and spirit. Article 16 of the African Charter on Human and Peoples' Rights (Banjul Charter) affirms the right of every individual to the best attainable state of health. As a signatory to this treaty, South Africa is obliged to take measures to enforce this right.

The United Nations Principles for the Treatment of Inmates[20] provides that inmates must have access to medical and health services equivalent to those available to the general population in their country of incarceration, without discrimination based on their legal standing.[21] The World Health Organization Guidelines on HIV Infection and AIDS in Prison provide that inmates have the right to receive healthcare which is equivalent to that available in the community.[22]

To this end, in line with section 233 of the Constitution provides that South Africa has an obligation to implement legislation, policies and programmes that are consistent with international human rights norms and standards.

13. *Emily Nagisa Keehn and Ariane Nevin*: "Health, Human Rights, and the Transformation of Punishment: South African Litigation to Address HIV and Tuberculosis in Prisons" Health and Human Rights Journal: 9 May 2018 accessed at ttps://www.hhrjournal.org/2018/05/health-human-rights-and-the-transformation-of-punishment-south-african-litigation-to-address-hiv-and-tuberculosis-in-prisons/#_edn42 on 07 April 2020
14. Universal Declaration of Human Rights adopted by the United Nations General Assembly on 10 December 1948 available at https://www.ohchr.org/EN/UDHR/Documents/UDHR_Translations/eng.pdf.
15. International Covenant on Civil and Political Rights adopted and opened for signature, ratification and accession by General Assembly Resolution 2200A (XXI) of 16 December 1966 available at https://www.ohchr.org/en/professionalinterest/pages/ccpr.aspx.
16. International Covenant on Social, Economic and Cultural Rights adopted and opened for signature, ratification and accession by General Assembly Resolution 2200A (XXI) of 16 December 1966 available at https://www.ohchr.org/Documents/ProfessionalInterest/cescr.pdf.
17. Universal Declaration of Human Rights above n14.
18. Motala and Mason "Do prisoners in South Africa have a constitutional right to a holistic approach to antiretroviral treatment?" *South African Journal of Bioethics & Law* 6(2) (2013) 40 at 41.
19. International Convent on Economic, Social and Cultural Rights above n 16.
20. United Nations "Basic Principles for the Treatment of Prisoners" (14 December 1990) adopted and proclaimed by General Assembly Resolution 45/111 available at https://www.ohchr.org/en/professionalinterest/pages/basicprinciplestreatmentof prisioners.aspx.
21. United Nations. Resolution 45/111: Basic Principles for the Treatment of Inmates. The Hague: United Nations, 1990
22 Joint United Nations Programme on HIV/AIDS and World Health Organization. Guidelines on HIV Infection and AIDS in Prison. Geneva and The Hague: UN and WHO, 1999.

3. Specific HIV and TB Related Rights of Inmates

3.1. Testing and Informed Consent

Section 12(4)(a)[23] of the Correctional Services Act prohibits the medical examination, intervention, or treatment without informed consent of an inmate, unless not doing so would be a threat to the health of other inmates. However, consent to surgery is not needed if a medical doctor decides that it is in the interests of the inmates' health, and the inmate is unable to give consent because he/she is unconscious.

The Department of Health Guidelines for TB and HIV Control in Correctional Facilities provides that voluntary HIV counselling and testing must be offered to all inmates at entry, during incarceration, and on release, at the request of an inmate, as part of routine screening campaigns, as part of integrated primary healthcare services. Furthermore, it is a requirement that '[s]ymptom-based TB screening must be conducted on all inmates at entry, during TB screening campaigns, when self-reported or peer referred, TB contacts, as part of integrated primary healthcare services, at least bi-annually and on release.'[24]

The importance of adequate pre-test counseling before an HIV test is conducted on an inmate, was emphasized in *C v Minister of Correctional Services*.[25] In this case, an inmate had been informed that he was being tested for HIV and that he had the right to refuse the test. The court held that there was a lack of privacy and reasonable time for reflection afforded to the inmate before being asked to consent to the test, the absence of the pre-test counseling thus resulted in the failure to obtain informed consent.[26]

The exceptions to the principle requiring an inmate's informed consent before going forward with medical testing is when the inmate is an alleged, suspected or convicted sexual offender. Part 2 of the Sexual Offences and Related Matters Amendment Act (Sexual Offences Act) deals with the application for compulsory HIV testing of alleged sex offenders by victims. The Sexual Offences Act provides that a victim or an interested person on behalf of the victim may apply to a magistrates' court within 90 days after the commission of the sexual offence for an order that the offender be tested for HIV 'and that the results thereof be disclosed to the victim or interested person, as the case may be'.[27]

3.2. The Right to HIV and TB Prevention and Treatment

The right to medical care in correctional services includes the provision of HIV and TB care and prevention, treatment of opportunistic infections, access to nutritional supplements, access to palliative care and compassionate release. The package of treatment should include nutritional support; adherence support; continuity of care; and the reduction of stigma and discrimination.

3.2.1. HIV Prevention and Treatment

The Correctional Services Act states that an inmate is entitled to healthcare and not just any standard of healthcare, but one which is in line with the primary principles of healthcare.

In 1997, *Van Biljon v Minister of Correctional Services*[28] two HIV-positive inmates took the DCS to court for denying them HIV treatment at State expense when they had reached a symptomatic stage of their disease and their CD4 count fell below 500/ml. The Court had to decide whether the state was required to provide this treatment at its own expense and more specifically whether the treatment claimed by the applicants constituted 'adequate healthcare'. The Court held that '[t]he standard of medical treatment given to inmates cannot be determined by 'the lowest common denominator of the poorest inmate'. Inmates are more exposed to 'opportunistic' viruses than HIV sufferers outside prison, as a result of overcrowding in prisons. The State, therefore, has a duty to provide inmates with better protection than that provided to patients outside prison.'[29] This judgment further expanded on the nature

23. Section 12*(4)(a)* of the Correctional Services Act.

24. Op cit note 10.

25. (1997) JOL 407 (T).

26. Ibid.

27 Sexual Offences and Related Matters Amendment act 24 of 2015.

28. 1997 (4) SA 441 (C).

29. Ibid at para 64. See also Ballard and Hobden "Public Interest Litigation and Prisoners' Rights" in Brickhill (ed) *Public Interest Litigation In South Africa* (Juta & Co Ltd, Cape Town 2018) at 357-8.

of healthcare that should be afforded by the state to an inmate.

In 2006, in the case of *EN and Others v. Government of RSA and Others*[30], a group of HIV-positive inmates together with the Treatment Action Campaign (TAC), sought a court order mandating the provision of HIV treatment to all people qualifying for treatment in Westville prison. The court ruled in favour of the applicants and ordered that all HIV-positive inmates at the prison who qualified for treatment according to national policy be given that treatment.

3.2.2. TB Prevention and Treatment

The Department of Health and the Department of Correctional Services guidelines for the management of TB and HIV infections in correctional centres introduced obligatory screening for TB of every offender entering, residing in or leaving a correctional centre, so that he or she can start treatment as soon as possible, should he or she be found to have TB. In addition, the Southern African HIV Clinicians Society Guidelines, recommend isolation for all prisoners with TB for the purpose of infection control to protect other inmates, particularly those living with HIV. It states that:[31]

> '[a]ll sputum smear- or culture-positive TB patients must be transferred to a separate designated isolation area within the facility, with adequate ventilation, sunlight (or, if not available, ultraviolet germicidal light) and infection control and treatment facilities. If a patient is identified as multidrug-resistant TB infected, they should be transferred urgently to a dedicated in-patient treatment site.'

The issue of TB and the state of health in South Africa's prisons was tested in *Lee v Minister for Correctional Services*.[32] The applicant, Mr Lee, was detained at Pollsmoor Maximum Security Prison from 1999 to 2004. During this period of incarceration, he contracted TB.[33] He sued the Minister for Correctional Services for damages on the basis that the poor prison health management had led to his becoming infected with TB. The High Court declared the Minister liable for delictual damages suffered by the applicant on the basis that the prison authorities had failed to take reasonable steps to prevent him from contracting TB whilst he was incarcerated in the maximum-security prison.[34] On appeal, the Supreme Court of Appeal[35] found that prison authorities had been negligent in failing to maintain reasonably adequate systems to manage TB, but Mr Lee had not proved that the presence of reasonable precautionary measures would have completely eliminated the risk of his contracting TB.[36] The Supreme Court of Appeal therefore upheld the Minister's appeal.[37]

Lee then appealed to the Constitutional Court. The majority of the Court held that the Supreme Court of Appeal, in applying the test for factual causation, had adopted a rigid deductive logic which necessitated the conclusion that, because Mr Lee did not know the exact source of his infection, his claim had to fail.[38] The court held that South African law has always recognised that the test for factual causation should not be applied inflexibly as the Supreme Court of Appeal had done. It also held that the approach adopted by the Supreme Court of Appeal meant that it was 'unlikely that any inmate would ever be able to overcome the hurdle of causation and further, no effective alternative remedy [would] be available to a person in the position of [Mr Lee]'.[39] The Court upheld Mr Lee's claim that there was a probable chain of causation between negligent omission by the correctional services authorities and his becoming infected with TB.[40] It emphasised that there is a legal duty on correctional services authorities to provide adequate healthcare services as part of the constitutional right of

30. 2006 (6) SA 575 (D).

31. Ibid. See also Ballard and Hobden above n29 at 358.

32. 2013 (2) SA 144 (CC).

33. *Lee v Minister of Correctional Services* 2011 (6) SA 564 (WCC) at para. 2.

34. Ibid. at para. 270.

35. *Minister of Correctional Services v Lee* 2012 (3) SA 617 (SCA).

36. Ibid. at para 64.

37. Ibid. at para 70.

38 *Lee v Minister of Correctional Services* at para 44.

39. Ibid. at para 65.

40. Ibid. at para 71.

all prisoners to conditions of detention that are consistent with human dignity.[41]

The minority decision of the Court held that the unique characteristics of TB, including how it is acquired and tested, mean that it is not possible to conclude on the existing test at common law that the negligence of the prison authorities more probably than not caused Mr Lee to contract TB. The minority agreed with the Supreme Court of Appeal that Mr Lee could not satisfy the test of causation but stated that the resultant injustice in cases such as this one, where the condition by its very nature defies the but-for enquiry test of causation, requires the courts to develop the common law. The evidence available was not sufficient 'to consider properly and justly all the avenues of possible development, and their implication for the parties' respective cases'.[42] The minority judgment would therefore have remitted the matter to the trial court 'for it to consider...the manner in which the common law ought to be developed'.[43]

The *Lee* case highlighted the differences between HIV and TB - HIV being blood-borne and TB airborne, for example – which pose different challenges and prompt different ways of assessing the right to access healthcare by using the law. However, most importantly the case re-emphasised the legal duty on the government to provide adequate healthcare services in terms of the constitutional right of all prisoners to conditions of detention that are consistent with human dignity.

3.3. Sexual Violence in Correctional Centres

The National Policy to Address Sexual Abuse of Inmates in Correctional Facilities[44] seeks to address the issue of Sexual violence in correctional services. The policy defines sexual abuse in correctional services as 'sexual conduct that takes place in the absence of consent, including all forms of sexual exploitation and harassment.'[45] It prohibits 'all non-consensual sexual contact between inmates, specifically, sexually abusive penetration, sexually abusive contacts, and sexual harassment' which it defines as follows:[46]

- Sexually abusive penetration: sexual penetration by an inmate of another inmate without the latter's consent which also includes compelling one inmate to rape another.[47]
- Sexually abusive touching: non-penetrative touching (either directly or through the clothing) of the genitalia, anus, groin, breast, inner thigh, or buttocks without penetration by an inmate of another inmate without the latter's consent. This includes contact between the mouth of one person and the body of another person, such as forced kissing. It is also prohibited for an inmate to force another to fondle him or her, or a third person.[48]
- Sexual harassment: repeated and unwelcome sexual advances, requests for sexual favours, verbal comments, gestures or actions of a derogatory or offensive sexual nature by an inmate directed toward another. Other prohibited acts include: displaying pornographic photographs, rubbing against a person in an indecent way, causing another person to witness sexual acts or making someone believe that s/he will be sexually violated.[49]

The conduct prohibited by this policy constitutes a crime under the Sexual Offences Act.[50]

3.3.1. Overcrowding

Overcrowding and poor ventilation in correctional centres contribute to the increased risk of airborne TB infection, while poor conditions are believed to heighten tension among inmates, which in turn fuels violence, including

41. Ibid. at para 65.
42. Ibid. at para. 115.
43. Ibid. at para. 116. See also Ballard and Hobden above n29 at 358-9.
44 Policy to Address Sexual Abuse of Inmates in Department of Correctional Services Facilities, 2011 available at https://doc-04-cc-docs.googleusercontent.com/docs/securesc/ha0ro937gcuc717deffksulhg5h7mbp1/3g1pdgp5n3b4fnjad4lomsqfe7ciiphm/.1604440875000/12470407650063003563/*/0ByMc18Au_16UWHNDY0ZZTVZnVWM?e=download.
45. Ibid at 71
46. Ibid at 65
47. Clause 3.2.1.1 of the of the Policy to Address Sexual Abuse of Inmates in Department of Correctional Services Facilities.
48. Clause 3.2.1.2 Ibid.
49. Clause 3.2.1.3 Ibid.
50. Clause 3.1.1 Ibid.

sexual violence.[51] These systemic conditions increases the risk of TB infection as well as STI's and HIV.

The issue of overcrowding in South African correctional centres was dealt with in the case of *Sonke Gender Justice v. The Government of the Republic of South Africa*.[52] In this case Sonke Gender Justice and Lawyers for Human Rights challenged the severe overcrowding and inhumane conditions of confinement for remand detainees. When the litigation commenced, Pollsmoor's remand facility was operating at over 238% capacity, accommodating nearly 2,000 people more than approved under national regulations. This meant that there were up to 70 detainees crammed into cells built for 30 people. Individuals were doubled up on beds or forced to sleep on the floor, even underneath beds. For 23 hours a day, detainees remained in their cells with no space to manoeuvre, and had only monthly access to exercise in the yard. The applicants relied on Justice Cameron's report[53] which confirmed the testimonies of current and former remand detainees that the conditions in Pollsmoor were 'hazardous and degrading' to inmates. The report described the facility as 'thick with a palpable lack of ventilation,' and that the conditions were 'so filthy that detainees [had] boils, scabies, wounds and sores from lice-infested bedding that [had] never been washed.' In addition, Justice Cameron reported frequent shortages in medicines for TB treatment, and difficulties for HIV-positive inmates in accessing treatment.

The Court found that the conditions of detention were a violation of detainees' constitutional rights to health and conditions of detention consistent with human dignity. The Court ordered the government to reduce overcrowding to no more than 150% of its approved capacity within six months. It also ordered DCS to develop a plan to rectify detention conditions and to report to the Court regularly on inspections of cell accommodation.

3.4. Bail, Sentencing and Early Release of Inmates with Terminal Illness

There are several common questions that are often asked when dealing with inmates-related issues in the context of HIV and TB. These questions relate to bail and sentencing of HIV-positive offenders; more specifically, to whether HIV can be used as a mitigating or aggravating factor in sentencing and whether a prisoner dying of AIDS can get early release from prison. Schedule 6 of the Criminal Procedure Act[54] (CPA) makes eligibility for bail more difficult in rape cases when an alleged sexual offender is known to be HIV-positive.[55] Offenders in such cases are ordinarily not granted bail unless they can prove the existence of 'exceptional circumstances.[56]

The Criminal Law (Sexual Offences and Related Matters) Amendment Act provides for life imprisonment of offenders convicted of aggravated rape who knew at the time of the offence, that they were HIV-positive. The Criminal Law Amendment Act does not stipulate the kind of evidence of HIV transmission required to support the imposition of a higher sentence. However, there are cases in which the HIV-positive status of a convicted offender has been considered a mitigating factor.

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51. Ibid. at para 117

52. According to the Policy sexual acts includes:
    (1) contact between the penis and the vagina or the anus;
    (2) contact between the mouth and the penis, vagina, anus;
    (3) forced contact between the mouth and an object representing genitals
    (4) Penetration of the anal or genital opening of another person by a hand, finger or other object.

53. Justice Cameron "Pollsmoor Correctional Centre-Remand Centre and Women's Centre" (2015) available at https://www.concourt.org.za/images/phocadownload/prison_visits/cameron/Pollsmoor-Prison-Report-23-April-2015-Justice-Edwin-Cameron-FINAL-for-web.pdf.

54. 51 of 1977.

55 AIDS and Human Rights Research Unit *Human Rights Protected? Nine Southern African Country Report on HIV, AIDS and the Law* (Pretoria: Pretoria University Law Press, 2007) at 265.

56. Section 60(11) of the Criminal Procedure Act.

57. Part I of Schedule 2 to the Criminal Law (Sexual Offences and Related Matters) Amendment Act.

58. AIDS and Human Rights Research Unit above n51 at 265.

In *Magida v S*,[59] one of the leading cases on HIV and sentencing, the court considered the link between the length of imprisonment and the health status of a prisoner. The Supreme Court Appeal, relying on *S v Cloete*[60] and *S v C*,[61] said that a Court considering an appropriate sentence 'may take into account a convicted person's ill-health and how it may relate to the effect of a contemplated sentence. Thus, for example, a particular sentence may be rendered more burdensome by reason of an offender's state of health.'[62] As a result, Maqida, who was living with HIV, was released. The court in Maqida reasoned that:

'[h]aving regard to all the factors [set out by the Court], including the fact that the appellant may die soon, and considering the seriousness of the offence, the interests of the appellant and of society,...further imprisonment is unwarranted....[A] sentence of imprisonment equal to the time spent in prison subsequent to the date on which the appellant had been sentenced by the magistrate is an appropriate one.'[63]

In *Stanfield v Minister of Correctional Service*,[64] the Court supported the granting of parole on medical grounds to terminally ill prisoners with HIV because 'even the worst of convicted criminals should be entitled to a humane and dignified death'.[65] Today, however, because HIV is regarded as a manageable chronic disease, the reasoning in this case may not be applicable to reducing a sentence or justifying early release from prison. Although there are circumstances in which the medical status of a prisoner is such that it does not justify a lengthy prison sentence, these circumstances are assessed on a case-by-case basis.

The Department of Correctional Services considers a range of factors in recommending early release on medical grounds, including medical evidence about the prisoner's condition, whether the condition is terminal, the type of crime committed and the length of the prison sentence served. This is the medical parole process guided by Chapter VII of the Correctional Services Act, with section 79 dealing specifically with medical parole. Unfortunately, the medical parole process in South Africa is often very bureaucratic, which results in delays in the granting of parole. Many prisoners die before they can be released into the care of their families. The Judicial Inspectorate for Correctional Services '2013/2014 Annual Report',[66] notes that prisoners have died whilst their application for medical release was following the course of the administrative processes of Department of Correctional Services. It also records that the Department indicated that the total number of medical releases for 2013/2014 were 20, stating that this figure is 'low', considering the number of deaths by natural causes, and that 'much effort' is required by the Department to ensure that 'the administrative processes are fluid and efficient'.[67]

4. Legal Remedies

4.1. Lodging a complaint with the Judicial Inspectorate of Correctional Services

Section 35(2)*(b)* of the Constitution states that every inmate has the right 'to choose, and to consult with, a legal practitioner, and to be informed of this right promptly'.[68] In correctional centres, inmates are able to

59 [2006] 1 All SA 1 (SCA). See also S v Belelie 1997 (2) SACR 79 (W); *S v Sibonyane* (unreported case, no. 14/2865/97, Pretoria Regional Court).

60. 1995 (1) SACR 367 (W).

61. 1996 (2) SACR 503 (T).

62. *Magida* above n 56 at para 17.

63. Ibid at para 20.

64. 2004 4 SA 43 (C)

65. Ibid.at para.18.

66. See fn6 above.

67. Ibid at 41.

68. A Vukeya Motsepe "Rights of Inmates living with HIV: access to treatment and prevention" in Amelia Vukeya Motsepe (eds) *"HIV and the Law in South Africa"* (2016) at 10.

report complaints to the head of the prison who should walk around the prison daily; however, sometimes these internal procedures fail. According to section 85(1) of the Correctional Services Act[69], the Judicial Inspectorate of Correctional Services (JICS), 'is an independent office under the control of the Inspecting Judge' and it is created to encourage and 'facilitate the inspection of correctional centres.' The Inspecting Judge can be a former or current judge[70] and reports on the treatment and conditions in prisons. 'In addition, the Judicial Inspectorate allows for the appointment of Independent Correctional Centre Visitors.[71] The powers, functions and duties of these visitors are set out in section 93 of the Correctional Services Act. Independent visitors must:

- visit prisons regularly;
- interview and record inmates' complaints;
- check up on complaints and what is being done about them; and
- hand over serious complaints to the Visitor's Committee or the Inspecting Judge'.[72]

The Constitutional Court has also created a system where each of the Court's judges visit a number of correctional centre each year in order to ensure that judges are familiar with prison conditions so that they can help improve these prison conditions and how prisons work and to help monitor and improve prison conditions, amongst other things.[73] After each prison inspection the judge compiles a report which is sent to the Minister of Justice and Correctional Services, the Commissioner of Correctional Services, the Parliamentary Portfolio Committee on Justice and Correctional Services and the Judicial Inspectorate. Cases of human rights violations against prisoners can also be reported to the South African Human Rights Commission.[74]

4.2. Internal Complaints

The Correctional Services Act provides for procedural steps that should be taken by an inmate whose rights have been violated and/or infringed.[75] In terms of the Correctional Services Act, the following steps should be followed:

- an inmate must, on a daily basis, be given the opportunity to make complaints and requests to the Head of the Correctional Centre or the correctional official authorized to represent the head of the Correctional Centre;
- this official must record the complaint and any steps taken in dealing with the complaint. The complaint must then be dealt with properly and the inmate must be informed of the outcome;
- if the inmate is unsatisfied with the outcome, he or she must indicate that to the Head of the Correctional Centre who will then refer it to the National Commissioner who must give a response to the inmate; and
- if the inmate is also not satisfied with the National Commissioner's response, the matter must be referred to an Independent Correctional Centre visitor to deal with it in terms of section 95 of the Correctional Services Act.[76]

69. 111 of 1998.

70. Section 86(1)(a) and (b) of the Correctional Services Act.

71. Section 92 of the Correctional Services Act.

72. Section 93 of the Correctional Services Act.

73. For further information on Constitutional Court prison visits and reports see http://www.constitutionalcourt.org.za/site/PrisonVisits/PrisonVisits.htm (last accessed 13 January 2015).

74. Other government and non-governmental organisations that prisoners can be referred to or seek legal assistance and other prison-related support from are the Legal Aid Board, NICRO, SAPOHR and Section27 (incorporating the AIDS Law Project).

75. Section 21 of the Correctional Services Act.

76. Ibid.

SUB-CHAPTER 4.4: FOREIGN NATIONALS

1. Introduction

Every person should by virtue of their essential humanity, enjoy all human rights.[1] In the same way as South Africans, foreign nationals should have "freedom from arbitrary killing, inhuman treatment, slavery, arbitrary arrest, unfair trial, invasions of privacy, refoulement, forced labour, child labour and violations of humanitarian law."[2] Respect for human rights is thus essential for the protection of refugees in South Africa. However, irrespective of the constitutional and legal protections they have in South Africa, foreign nationals face a number of distinct challenges in accessing services including social and healthcare services.

These challenges include:

- Inability to speak the local language of the area to which they have moved.
- Being unfamiliar with local systems or services.
- 'Knowledge gaps', particularly in relation to Human Immunodeficiency Virus (HIV), Tuberculosis (TB) and Sexual Transmitted Infections (STI's).
- 'Specific support needs owing to lack of traditional community and family support structures.'
- Reluctance of health professionals 'to make the extra effort necessary to deliver services to such individuals'
- '[D]iffering treatment regimens and treatment interruption' between area of origin and destination especially TB and HIV treatment.
- Health practitioners' lack of familiarity with refugee laws and rights.[3]

Unfortunately, there is no coherent policy dealing with health and welfare services specifically for foreign nationals[4] despite efforts to press the government to adopt one.[5] To make matters worse, the new regulations[6] published in December 2019 in terms of the Refugees Amendment Act 33 of 2008 are said to further undermine the rights of foreign nationals by creating more layers of administrative red-tape to an already struggling system.[7] The stringent application procedures and requirements puts unrealistic and impractical timeframes which will result in excluding asylum seekers of their rights to seek asylum in South Africa.[8] This exacerbates the gap between the rights conferred by law and the access to healthcare and welfare services foreign nationals because without proper papers, government officials in welfare service departments and healthcare service providers refuse to attend to the needs of foreign nationals without documentation.[9] The shortcomings in implementation often result from 'institutional failures, the denial of social services and abuse from the police, which manifest as ignorance, xenophobia and legal discrimination'.[10]

1. Office of the United Nations High Commissioner for Human Rights "The Rights of Non-Citizens" https://www.ohchr.org/Documents/Publications/noncitizensen.pdf at 1
2. Ibid at 5.
3. See L Bruns and P Spiegel 'Displaced persons and HIV care: Challenges and solutions' *The Southern African Journal of HIV Medicine* 5(26) (2007): 42–43 at 42.
4. F Belvedere, P Pigou and J Handmaker 'Realising rights: The development of health and welfare policies for asylum-seekers and refugees in South Africa' in J Handmaker, L de la Hunt and J Klaaren (eds) *Advancing Refugee Protection in South Africa* (New York and Oxford: Berghahn Books, 2007) at 242.
5. See *Scalabrini Centre of Cape Town and others v Minister of Social Development and others* (unreported Transvaal Provincial Division case, no. 32056/2005 In 2005 the Scalabrini Centre and other parties applied to have the government's policy on social assistance amended to include refugees in its scope. An order was made directing the government to develop a social assistance policy that would include refugees in its ambit. At the time of writing, no policy document has been issued making provision for refuges to receive social assistance. However, the 2008 regulations published under the Social Assistance Act 13 of 2004 provide refugees with social assistance to in limited circumstances. It would appear therefore that the *Scalabrini* case ultimately led to the inclusion of refugees in the 2008 regulations.
6. See Regulations Gazette No 11024 Volume 654 of 27 December 2019 No 42932 .
7. Scalabrini " Press release: New Refugee Law Undermine Human Rights of Refugee" 10 January 2020 accessed from https://scalabrini.org.za/wp-content/uploads/2020/01/Regulations-Refugee-Amendment-Act-2018.pdf at 15 March 2020.
8. Ibid
9. Op cit note 4 at 248.
10. J Vearey 'Migration, access to ART, and survivalist livelihood strategies in Johannesburg' *African Journal of AIDS Research* 7(3) (2008): 361–374 at p. 365.

2. South African Law and Foreign Nationals

South Africa guarantees equal treatment, non-discrimination and recognition of foreign nationals. Section 9(3) of the Constitution states that "[t]he state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth". The State or any person is prohibited from unfairly discriminating against any person 'on the basis of any other ground where discrimination causes or perpetuates systemic disadvantage, undermines human dignity or adversely affects the equal enjoyment of a person's rights and freedoms in a serious manner.'[11]

Although citizenship is not a listed ground of prohibited discrimination in section 9(3) of the Constitution, arbitrary discrimination on the basis of citizenship is unfair. This was confirmed in the case of *Larbi-Odam and others v MEC for Education (North-West Province) and another*,[12] where the Constitutional Court declared Regulation 2(2) of Regulations (GN R1743 of 13 November 1995) dealing with the terms and conditions of employment of educators invalid on the grounds that it was unfair discrimination inconsistent with s 8(2) of the interim Constitution. The regulation provided that, subject to certain exceptions, only South African citizens may be appointed to permanent teaching posts in state schools. In terms of the regulation, eight temporarily-employed teachers were issued with notices of termination. The teachers were foreign citizens, some of whom had permanent residence and some temporary residence permits. The court noted that citizenship was not a listed ground of prohibited discrimination in the Constitution but held that discrimination was unfair in that denying permanent residents job security when they are allowed to live and work in South Africa indefinitely (and to apply in due course for citizenship) was unfair discrimination.

Section 10 of the Constitution states that '[e]veryone has inherent dignity and the right to have their dignity respected and protected'. Foreign nationals also enjoy the right to be treated with dignity and to have their dignity respected and protected at all times.

There are two key pieces of legislation that governs foreign national, namely, the Refugees Act, as amended[13] and the Immigration Act.[14]

- The Immigration Act is the broader piece of legislation, governing entry to and departure from South Africa of foreign nationals.
- Refugees Act applies only to people who apply for or intend to apply for asylum. In general, foreign nationals may apply for a wide range of permits and visas in terms of the Immigration Act which will authorise them to enter and remain in South Africa.

There are also options for foreign nationals to apply for permanent residence and citizenship if they satisfy the requirements under the Immigration Act and other applicable legislation.

By definition a:

- 'a Refugee' is defined in section 1 of the Refugees Act as 'any person who has been granted asylum in terms of [that] Act' and 'asylum' as 'refugee status recognised in terms of [the] Act'.
- An 'asylum seeker' is 'a person who is seeking recognition as a refugee in the Republic'.
- An Immigrant is a person who comes to live permanently in a foreign country.[15] In order for a person to shift from undocumented migrant to asylum seeker and ultimately a refugee, he or she will have to apply using the process outlined in the Refugee Act.

3. International Law and its Application to Refugees in South Africa

'International human rights law is founded on the premise that all persons, by virtue of their essential humanity, should enjoy all human rights without discrimination.'[16]

11. Refugee law accessed from https://www.refugee.org/equality-court on 21 April 2020
12. 1998 (1) SA 745 (CC)
13. Act 130 of 1998.
14. Act 13 of 2002.
15 See Oxford dictionary definition of immigrant
16. The Office Of the United Nations Commissioner on Human Rights 'The rights of non-citizens' Geneva (2006) at 7

The exceptional distinction between citizens and non-citizens is only made when it serves a legitimate State objective and it is proportional to the achievement of that objective.[17] Therefore any approach to prevent discrimination against foreign nationals should take into account (a) The interest of the State in specific rights, for example political rights, right to education, social security, other economic rights); (b) The different non-citizens and their relationship to that State, for example, permanent residents, migrant workers, asylum-seekers, temporary residents, tourists, undocumented workers); and (c) Whether the State's interest or reason for distinguishing between citizens and non-citizens or among non-citizens, for example, reciprocity, promoting development, is legitimate and proportionate.[18]

Section 233 of the Constitution states that '[w]hen interpreting any legislation, every court must prefer any reasonable interpretation of the legislation that is consistent with international law over any alternative interpretation that is inconsistent with international law.'

The Refugees Act serves to give effect to South Africa's obligations under international law. Two key conventions set out the international framework for the protection of refugees in Africa: The United Nations Convention relating to the Status of Refugees (1951), read with the amending and updating Protocol adopted in 1967, and the OAU Convention Governing the Specific Aspects of Refugee Problems in Africa (1969). South Africa acceded to the United Nations Convention in January 1996 and signed and ratified the OAU Convention in December 1995. As a result, South Africa is obliged to protect refugees in its territory, in accordance with the terms of the Conventions. The following are other two key international conventions relevant to foreign nationals:

- International Covenant on Civil and Political Rights (ICCPR) which provides the general principle of equality that underlies international human rights law. Article 2 (1) of the ICCPR requires each State party to: 'undertakes to respect and to ensure to all individuals within its territory and subject to its jurisdiction the rights recognized in the present Covenant, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status." While Article 26 state that "All persons are equal before the law and are entitled without any discrimination to the equal protection of the law." As such, the law must prohibit any discrimination and guarantee all persons equal and effective protection against discrimination on any ground such listed in article 2(1).
- International Convention on the Elimination of All Forms of Racial Discrimination (ICERC) also provides for the principle of equality for all citizens and non-citizens and thus does not promote the "distinctions, exclusions, restrictions or preferences made by a State Party to this Convention between citizens and non-citizens."[19] The ICERC defines racial discrimination in article 1 (1) to mean 'any distinction, exclusion, restriction or preference based on race, colour, descent, or national or ethnic origin which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of human rights and fundamental freedoms in the political, economic, social, cultural or any other field of public life.'

4. Access to Healthcare Services Available to Foreign Nationals

Foreign nationals should enjoy the same access to healthcare services in respect of HIV and TB – including access to HIV testing, TB screening, treatment and health education – as those enjoyed by South African citizens. Human rights arguments in favour of equal access to healthcare services for all persons regardless of nationality, including undocumented migrants, are supported by public health concerns particularly in the context of HIV and TB.[20]

The South African National Strategic Plan 2017 – 2022 recognises migrants and undocumented foreign nationals as vulnerable populations for HIV, TB and (STI). This is because Refugees, asylum seekers and undocumented migrants are often the population whose rights are violated, including having limited access to private healthcare.

17. Ibid

18. Ibid

19. Article 1(2) of the International Convention on the Elimination of All Forms of Racial Discrimination.

20. A Hassim, M Heywood and J Berger (eds) *Health and Democracy: A Guide to Human Rights, Health Law and Policy in Post-apartheid South Africa* (Cape Town: Siber Ink, 2007) at 289.

4.1. The Application of Socio-Economic Rights in the Bill of Rights to Foreign Nationals

In terms of section 27 of the Constitution

(1) Everyone has the right to have access to –
   (a) healthcare services, including reproductive healthcare;
   (b) sufficient food and water; and
   (c) social security, including, if they are unable to support themselves and their dependants, appropriate social assistance.

(2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.

(3) No one may be refused emergency medical treatment.

To what extent, if any, is the government entitled to differentiate on the basis of nationality when providing healthcare services and emergency medical treatment?

Khosa and others v Minister of Social Development and others; *Mahlaule and others v Minister of Social Development and others*[21] concerned a constitutional challenge to statutory provisions that excluded permanent residents from certain forms of social assistance.[22] The applicants, Mozambican citizens who were also permanent residents in South Africa, approached the High Court for an order declaring the impugned provisions invalid. The High Court found that the provisions were indeed inconsistent with the Constitution and held that section 27 of the Constitution, the right to access to social security, read with section 9, the right to equality, required the state to provide social grants to all indigent residents who met the criteria for assistance irrespective of citizenship. The High Court referred the order of invalidity to the Constitutional Court for confirmation.

The Constitutional Court had to decide whether sections 3*(c)*, 4*(b)*(ii) and 4B*(b)*(ii) of the Social Assistance Act[23] infringed the right of the applicants to have access to social security in terms of section 27(1)(c) of the Constitution. It held that the right to social security vests in 'everyone' which, for the purposes of section 27(1)(c), embraces permanent residents:

This court has adopted a purposive approach to the interpretation of rights. Given that the Constitution expressly provides that the Bill of Rights enshrines the rights of 'all people in our country',[24] and in the absence of any indication that the s 27(1) right is to be restricted to citizens as in other provisions in the Bill of Rights, the word 'everyone' in this chapter cannot be construed as referring only to 'citizens'.[25]

The court held further that, while it is necessary for the state to use classifications to differentiate between people for the provision of benefits, those classifications must ultimately be 'reasonable' in terms of the Constitution. Therefore, the criterion of 'citizenship' had to be reasonable in order to pass constitutional muster.[26]

Other cases have also addressed differentiation between citizens and foreign nationals, confirming the application of the Bill of Rights to asylum seekers[27] and even to undocumented migrants[28] and requiring any limitation of the rights of these persons to be justified under section 36 of the Constitution.

In light of the language of section 27, which confers rights on 'everyone', as interpreted in *Khosa*, the point of departure in respect of the right of refugees, asylum

21. 2004 (6) SA 505 (CC).

22. S 3(c) of the Social Assistance Act 59 of 1992 reserved social grants solely for aged South African citizens. Ss 4(b)(ii) and 4B(b)(ii) of the same Act, as amended by the Welfare Laws Amendment Act 106 of 1997, reserved child-support grants and care-dependency grants for South African citizens only.

23. Act 59 of 1992.

24. S 7(1) of the Constitution provides that '[t]he Bill of Rights is a cornerstone of democracy in South Africa. It enshrines the rights of *all people in our country* and affirms the democratic values of human dignity, equality and freedom' (emphasis added).

25. *Khosa* (fn. 20 above) at para. 47.

26. Ibid. at para. 53.

27. See e.g. *Minister of Home Affairs and others v Watchenuka* 2004 (4) SA 326 (SCA) in which the court upheld a challenge to the prohibition on asylum seekers' working and studying while in South Africa.

28. See e.g. *Lawyers for Human Rights v Minister of Home Affairs* 2004 (4) SA 125 (CC) in which the court confirmed that the right to freedom and security of the person applies to 'illegal immigrants', too.

seekers and other foreign nationals to have access to healthcare, including healthcare in relation to HIV and AIDS, is that such persons have the same entitlements as do South African citizens. Any departure from this principle limits their right to have access to healthcare in terms of section 27 and their right to equality in terms of section 9 and must be justified.

Khosa demonstrates that the Constitutional Court will not easily accept differentiation between citizens and foreign nationals in the context of socio-economic rights. This will also apply in the context of access to healthcare for refugees, asylum seekers or even undocumented migrants.

4.2. Legislation and Policy Directives

Section 27 of the Refugees Act expressly confers certain rights on refugees including the right to *'the same basic health services and basic primary education which the inhabitants of the Republic receive from time to time'* (emphases added).[29] TB and Antiretroviral treatment and prevention of mother-to-child transmission constitute basic health services to which inhabitants of South Africa are entitled. Accordingly, section 27 of the Refugees Act confirms that refugees are also entitled to such treatment.

Section 4 of the National Health Act[30] governs eligibility for free health services in the public health sector. It does not refer to nationality or purport to limit the rights that it confers to any category of person by reference to citizenship or similar status. It therefore appears that the National Health Act applies to all persons in South Africa regardless of nationality and regardless of whether they are legally in South Africa or not, subject to any conditions prescribed by the Minister of Health in terms of section 4.

Studies have shown that, in practice, foreign nationals are able to access HIV testing and counselling including TB screening within the public health system but are not necessarily able to access treatment.[31]

On 19 September 2007 the Department of Health issued a directive to all Provincial Health Revenue Managers and HIV/AIDS Directorates, entitled 'Hospital Fees: Assessment of Refugee/Asylum-Seekers (with or without a permit)'. The directive refers to section 27 of the Refugees Act and the rights that it confers on all refugees in respect of healthcare. The directive says that refugees or asylum seekers with or without a permit who do access public healthcare 'shall be assessed according to the current MEANS test' (set out in Annexure H to the directive). In terms of the means test, non-citizens are 'full-paying patients', with the exception of permanent residents, non-South Africans with temporary residence or work permits, and persons from 'neighbouring states'[32] who enter South Africa illegally. These three categories of foreign nationals therefore appear to be entitled to free basic healthcare. The directive also provides that '[r]efugees/asylum seekers with or without a permit that do access public healthcare...shall be exempted from paying for ART services irrespective of the site or level of institution where these services are rendered'.[33] Unfortunately, it is common practice at public health facilities to turn away refugees and asylum seekers who do not have their permits.[34] The directive may be relied upon, at least in relation to ART, to demand treatment even without a permit. The directive states that '[r]efugees/asylum seekers whose income exceeds the prevailing means test shall be levied' as full paying patients In addition, the means test itself states that 'only South African citizens shall be entitled to free primary healthcare services'.[35]

It is therefore clear that, although the directive grants free access to basic healthcare and ART services to refugees and asylum seekers with or without a permit, the directive limits the access to healthcare services of foreign nationals, including refugees and asylum seekers, in certain respects. In this regard, the directive limits the constitutional right to healthcare set out in section 27 of the Constitution (as well as possibly the right to equality in section 9 and the right of children to basic healthcare services in section 28(1)*(c)*). Such a limitation may be

29. S 27(g).

30. Act 61 of 2003.

31. Vearey (fn. 6 above) at p. 371.

32. This appears to be a reference to SADC member states . See Hassim et al. (fn. 19 above) at p. 290.

33. But see Hassim et al. (fn. 19 above) at p. 290, stating that asylum seekers are excluded from access to ARV treatment and arguing that this exclusion is unconstitutional.

34. See CORMSA ' Protecting Refugees/Asylum Seekers and Immigrants in South Africa during 2010' April 2011 at 34 accessed on http://www.cormsa.org.za/wp-content/uploads/2008/06/CoRMSA-Report-2011.pdf

35. Annexure H at para. 5.

susceptible to constitutional challenge and would require justification in terms of section 36 of the Constitution.

It is important to note that in January 2019, Provincial Health departments received a letter from the National Department of Health directive them to charge foreign patients the maximum rate. This Directive was later withdrawn with statement that this directive should have never been issued. It is, however, not clear whether the withdrawal of the 2019 Directive means that that 2007 Directive remains effective.

5. Remedies

5.1. Non-judicial Remedies: Recourse when Health Professionals Fail to Deliver Services to Foreign Nationals

A variety of remedies may be available in relation to access to healthcare service to foreign nationals or refugees. In many instances, individual health professionals may fail or refuse to provide healthcare services to foreign nationals – on the grounds of nationality or otherwise – out of ignorance of the rights of such people. In such cases, a written complaint or letter of demand to the head of the relevant public health facility may suffice to secure the necessary healthcare.

When a state medical facility refuses to provide health services, a complaint may be lodged with the Department of Health or with a relevant body tasked to oversee this kind of service delivery such as the Public Protector or the South African Human Rights Commission.

In practice, it may also be useful to approach an organisation such as Doctors Without Borders[36] to provide a referral for a patient to access the public health system.[37] Sometimes, such organisations can also advise which public health facilities are most likely to provide the relevant healthcare services – for instance, at which particular clinic or hospital ARV initiation or TB treatment is available.

5.2. Judicial Remedies

5.2.1. High Court Application

In other cases, it may be necessary to litigate for access to healthcare by way of application proceedings in the High Court – to secure an order directing that the relevant treatment or other service be provided. Organisations such as Lawyers for Human Rights, Section27 and the Legal Resources Centre have successfully litigated such cases in the past. When treatment is refused on the basis of legislation or policy, it may be necessary to challenge the validity of that legislation or policy and seek an order striking it down. For instance, if a foreign national is refused free treatment on the basis of the 2007 directive referred to above, it may be necessary to challenge the constitutional validity of that portion of the directive. When treatment is required immediately, urgent proceedings may be necessary. When refusal or failure to provide healthcare is systemic, a structural interdict is an option to consider.

5.2.2. Equality Court

The Equality Courts were created by the Promotion of Equality and Prevention of Unfair Discrimination Act (PEPUDA) which was enacted as a direct result of section 9, read with item 23(1) of Schedule 6, of the Constitution. PEPUDA designates all Magistrate's Courts and High Courts as Equality Courts for their area of jurisdiction.

Foreign nationals can institute proceedings at the Equality Court. These proceeding can also be instituted on their behalf or, 'or in the interests of, a group or class of persons, by any person acting in the public interest or by any association acting in the interests of its members'[38] Proceedings can be instituted using a prescribed form by notifying the clerk of the equality court of his or her intention to do so.[39] Upon submission of this form the following process takes place:

- The Equality clerk will then notify the respondent within 7 days, who, in turn, has 10 days to reply.

36. See the MSF's website at www.msf.org.za. MSF is the abbreviation of the organisation's French name, Médecins Sans Frontières.

37. Other organisations that provide health assistance include the Cape Town Refugee Centre and, in respect of trauma, the Centre for the Study of Violence and Reconciliation.

38. Section 20(1) of PEPUDA

39. Section 20(2) PEPUDA read with Reg 6(1).

- The Presiding Officer has 7 days to decide whether the matter is to be heard at the Equality court or referred to an alternative forum. If the Presiding Officer decides to hear the matter, two hearings will take place.
  - » The first is the Directions Hearing, at which all parties will be present.
  - » The second is Hearing on the Merits to make a decision on the facts presented by the parties.

The Equality Court has the power to make the following orders:

- interim order;
- declaratory order;
- an order making a settlement between the parties to the proceedings an order of court;
- an order for the payment of damages;
- an order restraining unfair discriminatory practices or directing that specific steps be taken to stop the unfair discrimination;
- an order to make specific opportunities and privileges unfairly denied available to the complainant;
- an order for the implementation of special measures to address the unfair discrimination, an order that an unconditional apology be made;
- an order requiring the respondent to undergo an audit of specific policies or practices as determined by the court; and
- an order of costs against any party to the proceedings or an order to comply with any provision of the Act.

6. Conclusion

Foreign nationals including refugees, asylum seekers and undocumented migrants continue to face obstacles in accessing healthcare. This is especially true of undocumented migrants. In terms of the South African legislation, refugees and other foreign nationals are entitled to free basic healthcare services and any exclusion based on nationality would be unlawful. The Department of Health's 2007 and 2009 directive confirms that HIV and TB treatment specifically, must be provided to anyone, including foreign nationals, without charge and without exclusion if the applicable means test is met. The law accordingly guarantees that foreign nationals are at least able to access basic healthcare services and especially TB and HIV treatment. The National Strategic Plan 2017–2022 also see it as imperative to address access to healthcare for foreign national to address broad public needs. In practice, though, exclusion and discrimination remain lamentably common occurrences and foreign nationals continue to die preventable deaths after being turned away from public healthcare facilities.

SUB-CHAPTER 4.5: SEX WORKERS

1. Introduction

1.1. Defining Sex Work

The South African National Strategic 2017-2022[1] defines sex work as 'consensual sex between adults which can take many forms, and varies between and within countries and communities.' Sex work also varies in the degree to which it is more or less 'formal', or organised.[2] The South African National Sex Worker HIV Plan 2016-2019 (Sex Worker Plan)[3] defines a sex worker as a 'consenting adult (18 years or older) male, female or transgendered person who works in different settings with the primary intention of exchanging money for sex.'[4]

Sex workers are a key and vulnerable population that faces a higher risk of HIV exposure and are more likely to transmit HIV because they have a greater HIV prevalence rate.[5] The Sex Worker HIV Plan states that the prevalence rate in South Africa among female sex workers ranges from 40% to 88%, significantly higher than the 14.4% (95% CI 13.3-15.6) prevalence among adult women in the general population.[6]

1.2. Why are Sex Workers Vulnerable to HIV?

Research has shown that sex workers' access to healthcare, including access to HIV prevention programming, has been obstructed by the criminalisation of sex work.[7] In many societies sex work is regarded as immoral. Religious and conservative groups regard sex work as a 'danger to health, morality and social order'.[8] As a result, sex work is 'incredibly stigmatised' and people engaging in sex work are seriously marginalised and discriminated against.

In general sex workers are particularly vulnerable to HIV infection for the following reasons:

- Sex workers are not always able to insist that their clients use condoms and are therefore vulnerable to contracting sexually transmitted infections. In addition, sex is often violent, which can result in vaginal and anal injuries;
- For as long as sex work remains illegal, it may be difficult for sex workers to get information about HIV and safer sex practices because they may not want to inform organisations that provide this information that they are sex workers. For the same reason, organisations that conduct HIV-prevention work may find it difficult to reach sex workers because sex workers are likely to keep their activity secret because it is illegal;
- Sex workers may find it difficult to access healthcare services when they have sexually transmitted infections for fear that they will encounter negative attitudes from healthcare workers if they disclose that they are sex workers;
- Sex workers may also have difficulty in protecting themselves from rape and abuse in that they may choose not to report these crimes to the police for fear of being arrested themselves. In many instances, sex workers have been abused and victimised by the police; and
- Police victimisation and searching of suspected sex workers for condoms as evidence of prostitution can lead sex workers carrying and using fewer prophylactics.[9]

1. South Africa's National Strategic Plan For HIV, TB and STIs 2017-2022 available at https://sanac.org.za//wp-content/uploads/2017/06/NSP_FullDocument_FINAL.pdf.
2. Ibid at 107.
3. The South African National Sex Worker HIV Plan 2016-2019 available at https://www.fast-tractcities.org/sites/default/files/South-African-National-Sex-Worker-HIV-Plan-2016-2019.pdf. last accessed on 3 November 2020.
4. Ibid at 11.
5. UNAIDS "Judging the Epidemic: A Judicial Handbook on HIV, Human Rights and Law" (2013), at 155 available at http://www.unaids.org/sites/default/files/media_asset/201305_Judging-epidemic_en_0.pdf.
6. The South African National Sex Workers HIV Plan 2016 – 2019 at 13 available at https://southafrica.unfpa.org/sites/default/files/pub-pdf/South%20African%20National%20Sex%20Worker%20HIV%20Plan%202016%20-%202019%20FINAL%20Launch%20Copy...%20%282%29%20%281%29.pdf last accessed on 20 June 2020.
7. Human Rights Watch "Why Sex Work Should be Decriminalised in South Africa" (2019) available at https://www.hrw.org/sites/default/files/report_pdf/southafrica0819_web_0.pdf last accessed on 17 March 2020 at 13.
8. Quan and Ward "All of us count – Part I: Developing policy and advocacy skills for the involvement of affected communities in responding to HIV/AIDS", at 16 available at http://www.hivpolicy.org/Library/HPP000130.pdf.
9. Human Rights Watch "Why Sex Work Should be Decriminalised in South Africa" (2019) available at https://www.hrw.org/sites/default/files/report_pdf/southafrica0819_web_0.pdf last accessed on 17 March 2020 at 21.

Despite advocacy and lobbying for the decriminalisation of sex work in South Africa, the law remains unchanged, to the detriment of the fight against HIV. As a result sex workers:

- continue to suffer violence from clients, society, their partners and the police;
- continue to work in unsafe and dangerous conditions;
- find it difficult to access health, social, police, legal and financial services;
- find it hard to protect themselves and their clients from HIV; and
- find it hard to get tested and get treatment for HIV.

2. South African Law and Sex Work

The Sexual Offences Act[10] prohibited the sale of sex. It did not however, prohibit the purchase of sex. Section 20(1A)(a) of the Sexual Offences Act provided that any person who 'has unlawful carnal intercourse, or commits an act of indecency, with any other person for reward' is guilty of an offence. In essence, the sale of sex is illegal including any activity connected with 'prostitution' such as owning a brothel.

Several women's organisations engaged with the South African Law Reform Commission to reform the criminalisation of sex workers. The attempt to decriminalise sex work failed in 2002 when the Constitutional Court overturned the decision of the High Court in *S v Jordan*[11] where the appellants, including a brothel owner who was also a sex worker, claimed that the Sexual Offences Act violated their rights to equality, privacy, human dignity, economic activity to pursue a livelihood, as well as freedom and security of the person. Briefly, the matter involved an incident in 1996, where a policeman went to a brothel in Pretoria and paid R250 for a pelvic massage. The brothel owner, Ellen Jordan, and two of her employees, Louisa Broodryk and Christine Jacobs, were arrested.[12]

A magistrate found them guilty of brothel-keeping and providing sex for reward. They appealed the decision in the High Court. The High Court declared that the Sexual Offences Act was discriminatory and should be declared unconstitutional but upheld the magistrate's guilty verdict on brothel-keeping. The case went to the Constitutional Court in 2002.[13]

The Constitutional Court overturned the High Court decision and upheld the constitutionality of criminalising unlawful sexual intercourse for reward under section 20(1) of the Sexual Offences Act as well as the brothel keeping provisions. The Constitutional Court, however, stated that the regulation of sex work is a matter that should be decided by Parliament because Parliament is best placed to decide how to regulate sex work in the context of the South African Constitution.[14] The minority judgment resulted in the legislature ultimately criminalising both the purchase and sale of sex in the Criminal Law (Sexual Offences and Related Matters) Amendment Act.

There are two conflicting approaches to sex work which have emerged over time:

- The first approach favours the elimination of sex work, arguing that prostitution is immoral or a form of violence against women and men.[15]
- The second approach supports the decriminalisation of sex work without focusing on how or why a person became a sex worker.[16] This approach aims to promote the safety and human rights of all people.

2.1. The Immorality Approach

The enforcement of morality through criminal law in South African jurisprudence predates the period before the constitutional transition. One such law is the Immorality

10. 23 of 1957.
11. 2001 (10) BCLR 1055 (T).
12. Ibid at 1057-8.
13. *S v Jordan and others* 2002 (6) SA 642 (CC).
14. Ibid at para 128.
15. Ibid.
16. UNAIDS 'Ending overly broad criminalization of HIV non-disclosure, exposure and transmission: Critical scientific, medical and legal consideration' (2013) accessed from http://www.unaids.org/sites/default/files/media_ asset/20130530_Guidance_Ending_ Criminalisation_0.pdf on February 2020.

Act[17] which declared consensual sexual acts between white and non-white people a criminal act punishable by criminal law. Other acts criminalised by the Immorality Act included homosexuality and the possession of pornographic material.[18] Although the criminalisation of these acts was declared unconstitutional[19] after 1994, adult consensual sex work still remains a criminal offence.

2.2. The Human Rights Approach

The human rights approach to sex work and access to healthcare is simple: regardless of one's personal view on sex work and sex workers, 'addressing the laws and policies that have a detrimental impact on their health and human rights is crucial to tackling the [HIV] epidemic'.[20]

In 2017, the South African Law Reform Commission Report recommended that the Sexual Offences Act be modified and updated but that criminalisation of both the sale and purchase of sex be retained.[21] However, despite these recommendations and lobbying from various groups the criminalisation of sex work has remained in force.

2.2.1. Rights of Sex Workers and the Prevention of HIV

The right to access healthcare for sex workers, including the right to sexual and reproductive healthcare that is non-judgmental, can reduce new HIV infections in South Africa.[22] The South African Commission for Gender Equality has noted that criminalisation of sex work violates sections 10, 12 and 22 of the Constitution which protect the right to human dignity, freedom and security of the person, and freedom of trade and occupation respectively. Decriminalising sex work would recognise it as a form of labour and enable its regulation by occupational health and safety laws, thus enabling better working conditions for sex workers. Decriminalisation would further make it easy to report brothel owners who are involved in human trafficking, especially in the trafficking of women and children. More importantly, it would allow the proper establishment of HIV prevention programmes and health services targeted at sex workers, which would in turn reduce the spread of HIV.

Despite the existing criminalisation of sex work, in 2016 the South African government launched the National Sex Worker HIV Plan 2016-2019. The aims of the plan include:

- increased provision of pre-exposure prophylaxis (PrEP)- (a treatment wherein HIV antiretrovirals (ARVs) are taken by HIV-negative individuals to help prevent infection(and the implementation of the 'Universal Test and Treat' protocol (where all people living with HIV are provided with medication as early as possible, no matter their CD4 count);[23]
- reaching 70 000 sex workers over three years through a peer educator-led approach and a minimum package of services including HIV prevention and treatment, psychosocial support, legal support, and economic empowerment;[24]
- at least 95 percent of sex workers use condoms with their clients and partners and that gender-based violence against sex workers falls by 50 percent, and that the global goals of "90-90-90" are met for sex workers;[25]

17. 5 of 1927.
18. Radebe "The Unconstitutional Criminalisation of Adult Sex Work" (University of Pretoria) 2013 at 2.
19. In *Curtis v Minister of Safety & Security* 1996 (3) SA 617, the court held that section 2(1) of the Indecent or Obscene Photographic Matter Act was unconstitutional and violated the constitutional right to privacy. The Act prohibited the possession of indecent or obscene photographic materials. In *S v Kampher* 1997(2) 417(C) at paras 31 and 61 and *National Coalition for Gay & Lesbian Equality v Minister of Justice* 2000 (1) BCLR 39 (CC) at para 108 it was held that the criminalisation of sodomy was incompatible with the constitutional rights to equality and privacy. In *Geldenhuys v National Director of Public Prosecutions & Others* 2009 (2) SA 310 (CC) at para 45, the Constitutional Court declared certain parts of sections 14(1)(b) and 14(3)(b) of the Sexual Offences Act 23 of 1957 invalid. These sections set the age of consent for sexual intercourse at nineteen for same-sex sexual acts, while setting the age of consent at sixteen for heterosexual sexual acts.
20. Ibid at 154.
21. South African Law Reform Commission, 2017, Project 107: Sexual Offences: Adult Prostitution (26 May 2017) available at https://www.justice.gov.za/salc/reports/r-pr107-SXO-AdultProstitution-2017.pdf.
22. Ibid at 25-6.
23. The South African National Sex Worker HIV Plan above n3 at 6.
24. Ibid at 15.
25. Ibid. The '90-90-90' goal refers to the goal set out by UNAIDS that 90 percent of sex workers know their HIV status, 90 percent of those who test positive are on antiretroviral treatment, and 90 percent of those on ARVs are virally suppressed. More generally, the '90 90 90' target is to be reached by 2020 for everyone not only sex workers.

- recruitment of 1,000 peer educators to address the multiple drivers of HIV and opportunistic infections;[26] and
- decriminalising sex work and addressing the social and structural barriers that confront sex workers on a daily basis.

The plan recognises criminalisation of sex work as one of the structural factors that intensify sex workers' vulnerability to HIV infection. It further recognises the impact of the criminalisation of sex work in inhibiting legal recourse in response to violence and human rights abuses.[27]

3. Legal Remedies

3.1. Sex Workers Rights under South African Law

A supportive legal environment that allows for the provision of healthcare services to sex workers is vital in the fight against HIV and TB. In this regard, legal practitioners can play a role in protecting the rights of sex workers by ensuring that sex workers receive the full protection of the law when they are assaulted, wrongfully arrested or denied access to healthcare services due to stigma and discrimination. The Bill of Rights affirms the democratic values of human dignity, equality and freedom. Section 7 obliges the state to respect, protect, promote and fulfil the rights conferred by the constitution.

For purposes of advising clients who are sex workers, legal practitioners need to consider the protection of sex workers in terms of the following sections:

Section 27 of the Constitution provides that everyone – including sex workers – has the right to access healthcare services. The State must take reasonable legislative and other measures to achieve the progressive realisation of this right. Section 10 provides that everyone has inherent dignity and the right to have their dignity respected and protected whilst section 9 protects the right to equality and prohibits unfair discrimination. The criminalisation of sex work results in sex workers suffering the indignity of discrimination, police abuse, stigma from service providers, and other rights violations.[28] Any conduct that makes it difficult for sex workers to access health services or violates sex workers rights to human dignity, equality and freedom will amount to a violation of their constitutional rights.

Section 12(1) and (2) of the Constitution provides that everyone has the right to freedom and security of the person, including the right not to be deprived of freedom arbitrarily or without just cause, the right not to be detained without trial, and the right to be free from all forms of violence from either public or private sources. Section 12 also guarantees freedom from torture, and the right not to be treated or punished in a cruel, inhuman or degrading way. Section 12 of the Constitution can be read with the Prevention and Combating of Torture of Persons Act[29] which specifically prohibits acts of torture. In addition, the Criminal Procedure Act[30] determines that anyone who is arrested should be informed of the reasons thereof immediately and told what they are being arrested for immediately and should not be held for longer than 48 hours without being taken to court.[31]

Furthermore, paragraph 2 of the policy on the Prevention of Torture and the Treatment of Persons in Custody of the South African Police Service[32] states that 'No member [of the Police] may torture any person, permit anyone else to do so, or tolerate the torture of another by anyone' as prohibited by 12(1) of the Constitution. This is also in line with the United Nations Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment of 1984 which South Africa ratified.

Section 22 of the Constitution provides that every citizen has the right to choose their trade, occupation

26. Ibid.
27. Ibid at 8.
28. Ibid at 63.
29. 13 of 2013.
30. 51 of 1977.
31. In terms of s 50(1)(c) of the Criminal Procedure Act an arrested person against whom a charge has been brought and who has not been granted bail by the police must be brought before a lower court as soon as reasonably possible but not later than 48 hours after the arrest.
32. The Policy on the Prevention of Torture and the Treatment of Persons in Custody of the South African Police Service available at https://acjr.org.za/resource-centre/SAPS_Policy_Torture.pdf@@download/file/SAPS_Policy_Torture.pdf last accessed on 3 November 2020.

or profession freely. The practice of trade, occupation or profession may be regulated by law. It has been argued that sex work can never be a trade of free choice.[33] However, sex worker activists have argued that they do this work voluntarily in order to support themselves and their families similar to any other person that is in another trade.[34] Therefore, it could be argued that sex workers who engage in sex work voluntarily should be afforded their freedom to practice their trade.[35] The Commission for Gender Equality has also noted that 'criminalisation violates sex workers' right to free choice of work by making a legitimate form of labour illegal' and that 'criminalisation violates sex workers' right to freedom of association because they are effectively barred from unionising and cannot engage in collective bargaining.'[36]

Section 23(1) of the Constitution provides that everyone has the right to fair labour practices. In *Kylie v CCMA and Others*[37] a sex worker referred a matter to the Commission for Conciliation, Mediation and Arbitration (CCMA) after being dismissed from her employment at a brothel in Cape Town. The CCMA said that it did not have jurisdiction over the case, since the work that Kylie was engaged in as a sex worker is illegal in South Africa. Therefore, Kylie could not be protected from unfair dismissal under the Labour Relations Act (LRA).[38] As such, Kylie could not claim protection under the LRA for a criminalised offence.

Section 39(2) of the Constitution requires any court or tribunal when it interprets legislation to take into account the 'spirit, purport and objects' of the Bill of Rights.[39] Thus, 'any tribunal called upon to interpret the definition of employee' in the LRA is constitutionally required to do so with reference to section 23 of the Constitution. While it may be correct to say that the CCMA was preventing the enforcement of criminalised conduct and therefore lacked jurisdiction, it can be argued that 'as far as the protection of vulnerable groups such as sex workers are concerned, the Bill of Rights now requires an expansive interpretation of the definition of employer in the LRA to include protection for vulnerable groups like sex workers who harm no one when they engage in consensual sex as adults, but who are harmed by the lack of protection of their trade thereof'.[40]

In *Khosa v Minister of Social Development*[41] Ngcobo J stated that the word 'everyone' in section 23 'is a term of general import and unrestricted meaning. It means what it conveys. Once the state puts in place a social welfare system, everyone has a right to have access to that system.'[42] Voluntary sex work should also be protected under the constitutional right to fair labour practice.[43] It can be argued that sex workers 'have the right to choose the type of work that they want to do (provided it does not harm or directly affects another person negatively).'[44] Thus, if a person engages in sex work as a form of work, his or her rights should be protected. In addition, the state bears a duty to ensure that the working conditions of that particular person are protected and regulated by law.[45]

3.2. Sex Workers Rights under international Law

International law does not prescribe any particular legal framework for the regulation of sex work. However, it is the duty of the state to adopt a legal framework that

33. Choma & Nyathi – Mokoena "Prostitution under the Sexual Offences Act in South Africa; A Constitutional Test" (2013) 3(1) *International Journal of Humanities and Social Science* at 235.
34. The South African National Sex Worker HIV Plan above n3 at 51- 6.
35. Choma above n 42 at 235.
36. Human Rights Watch World Report 2010, available at https://www.hrw.org/sites/default/files/reports/wr2010.pdf on 24 June 2020 at 63.
37. 2010 (4) SA 383 (LAC).
38. 66 of 1995.
39. National consolidated guidelines for the prevention of mother-to-child transmission of HIV (PMTCT) and the management of HIV in children, adolescents and adults, (December 2014) available at http://www.sahivsoc.org/upload/documents/ART%20Guidelines%20 15052015.pdf.
40. Ibid.
41. 2004 (6) SA 505 (CC).
42. Ibid at para 111.
43. Choma above n 42 at 235 -6
44. Ibid at 234.
45. Ibid.

respects the fundamental rights of individuals engaged in sex work. For example, sex workers have the right not to be arbitrarily arrested or detained, the right not to be subject to torture and other cruel, inhuman, or degrading punishment, the right to due process, and the right to the highest attainable standard of health.[46] More often than not, sex workers are arbitrarily arrested and their rights routinely disregarded, with the arrests often occurring at times when the sex workers are actually not engaged in offending behaviour or illegal conduct. Human rights standards require the law to be foreseeable and predictable and therefore requires States to define precisely and in a foreseeable manner all criminal offences. Failure to do so infringes upon the due process rights of a person accused of the offence.[47]

South Africa is party to major international and regional human rights treaties which require state parties to protect the rights of sex workers and prevent human rights violations against them. This includes taking steps to eliminate human trafficking and all appropriate measures to prevent sexual exploitation of children.[48]

Article 23 of the Universal Declaration of Human Rights[49] (UDHR) provides that everyone has the right to work, to free choice of employment, and to just and favourable conditions of work.

In addition, article 20 of the UDHR allows the right to freedom of assembly and association which means that sex workers have a right to associate, just like any other individual. As such, the law that prohibits them from working from a house or from working together in brothels may be challenged on the basis of the UDHR.

3.3. Remedies Against Unlawful Arrests

An unlawful arrest is an arrest which is made by a police officer on unlawful grounds. Examples include, amongst others, an officer who exceeds his or her authority or an officer who restricts a person's freedom of movement in an unjustified manner.[50]

Section 40(1)(b) of the Criminal Procedure Act states that 'A peace officer may without warrant arrest any person... whom he reasonably suspects of having committed an offence referred to in Schedule 1, other than the offence of escape from lawful custody'. As such, a police officer may only arrest without having a warrant if witnessing

46. The South African National Sex Worker HIV Plan above n3 at 25.

47. Ibid.

48 International Covenant on Civil and Political Rights (ICCPR) and both Optional Protocols: Article 9 of the ICCPR guarantees that:
- "Everyone has the right to liberty and security of person. No one shall be subjected to arbitrary arrest or detention. No one shall be deprived of his liberty except on such grounds and in accordance with such procedure as are established by law." Further, upon arrest, everyone "shall be informed, at the time of their arrest, of the reasons for his arrest and shall be promptly informed of any charges against him."
- "Any person detained on grounds that are not in accordance with the law is detained arbitrarily and therefore unlawfully. Detention can also amount to arbitrary detention, even if it is authorised by law, if it includes "elements of inappropriateness, injustice, lack of predictability and due process of law."
- The UN Human Rights Committee has determined that legally authorised detention must be reasonable, necessary, and proportionate, taking into account the specific circumstances of a case. International law requires states to ensure that necessary procedural guarantees are in place to identify and respond to situations of unlawful or arbitrary deprivation of liberty. Detainees must have a right to challenge their detention in court. In all situations where people are deprived of their liberty, the ICCPR states that they should still be treated "with humanity and with respect for the inherent dignity of the human person."
- The ICCPR also prohibits torture or cruel, inhuman or degrading treatment or punishment. Rape and sexual assault in detention is a form of torture. Under the ICCPR, states must provide "adequate medical care during detention."
- The UN's Standard Minimum Rules for the Treatment of Prisoners further clarifies that detainees are entitled to see a medical officer for their physical and mental health needs. This includes access to medicines necessary for their survival, such as anti-retroviral treatment (ART); the International Covenant on Economic, Social and Cultural Rights (ICESCR); the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and its Optional Protocol: Article 11 (1) provides for State parties to take all appropriate measures to eliminate discrimination against women in the field of employment in order to ensure, on a basis of equality of men and women, the same rights, in particular the right to work as an inalienable right of all human beings. Since prostitution may be regarded as employment it therefore implies that prostitutes deserve to work under free, safe and fair working conditions just like any other class of employees; the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Convention against Torture); and the Convention on the Rights of the Child (CRC) and two of its Optional Protocols. African Charter on Human and Peoples' Rights, as well as its Protocol on the Rights of Women in Africa.

49. Universal Declaration of Human Rights adopted by the United Nations General Assembly on 10 December 1948 available at https://www.ohchr.org/EN/UDHR/Documents/UDHR_Translations/eng.pdf.

50. Tumi Mokobe 'Unlawful arrest' (23 May 2018) available at https://www.nvrlaw.co.za/NewsResources/NewsArticle.aspx?ArticleID=2455 last accessed on 23 June 2020.

a crime or when there is reasonable suspicion that a person has committed what is known as a Schedule 1 offence such as rape, robbery or arson.

Sex work is not listed as a Schedule 1 offence so police officers often would use municipal by-laws, such as loitering provisions, to arrest sex workers without a warrant. An unlawful arrest infringes section 10 of the Constitution which recognises that everyone has inherent dignity and protects an individual's right to have their dignity respected and protected and section 12 of the Constitution which acknowledges the right to freedom and security of every person, and protects the right not to be deprived of freedom arbitrarily or without just cause; and not to be detained without trial.

In *The Sex Worker's Education and Advocacy Taskforce v Minister of Safety and Security and Others*,[51] SWEAT obtained some protection against unlawful arrest of sex workers, securing an interdict against arrest for any purpose other than prosecution.[52]

An unlawful arrest may lead to civil proceedings being instituted against the State. A victim of unlawful arrest may claim damages against the Minister of Police if he or she successfully proves his or her case in a court of law.[53] Claims may be made against the Minister as the employer of the arresting police officer/s in the following circumstances:

- if the arrest led to injury, a monetary claim for medical expenses (past and future medical costs) can be made;
- if an individual is employed and was detained for a certain period of time without valid grounds , a claim for past and future loss of income can be made; and
- if an individual suffered loss of freedom, dignity and suffering during the arrest, general damages can be claimed.

3.4. Non-Judicial Remedies Against Unlawful Arrests

3.4.1. Complaints Against the South African Police Services (SAPS)

Violence, sexual assault and rape of sex workers is commonly perpetrated by clients and law enforcement officials. Police officers often abuse a range of their powers including, among others, the power of arrest and powers of search and seizure.[54] Police officer often abuse their powers, by using public by-laws and other regulations to harass sex workers without following proper procedures.[55] Documented police abuse of sex workers include rape and gang rape, unlawful arrest when walking to the shops, demanding bribes such as money or sex, finding condoms on sex workers and using that as 'evidence' that sex work has taken place and sometimes confiscating these and not believing sex workers when they report crimes such as having been raped.[56]

The illegality of sex work under South African law does not in any way give the right to treat sex workers differently and arbitrarily. Sex workers have a right to access to justice and to the rights set out in the Bill of Rights and other laws and policies.

There are various avenues through which the public, including sex workers, can lodge complaints against members of the SAPS:

3.4.1.1. Independent Police Investigative Directorate (IPID)[57]

The IPID was established by the Independent Police Investigative Directorate Act[58] in line with Sections 205 to 208 of the Constitution which seek to regulate policing in South Africa. IPID reports to the Minister of Police and functions independently of the SAPS. The aim of the IPID is to ensure independent oversight over SAPS and the Municipal Police Services (MPS), and to

51. 2009 (6) SA 513 (WCC).

52. Meyersfeld and Nyembe "Gender and Public Interest Litigation In Post Apartheid South Africa: Have 'Systematic Motifs of Discrimination' Been Addressed?" in Brickhill (ed) *Public Interest Litigation In South Africa* (Juta & Co Ltd, Cape Town 2018 at 195.

53. *De Klerk v Minister of Police* 2018 (2) SACR 28 (SCA) (28 March 2018)

54. Bruce 'Police Brutality in South Africa' in Mwanajiti (ed) *Police Brutality in Southern Africa – A Human Rights Perspective* (Inter African Network for Human Rights and Development (Afronet) 2002) available at http://www.csvr.org.za/docs/policing/policebrutality.pdf at 4

55. The South African National Sex Worker HIV Plan above n3 at 3-4

56. Ibid.

57. Independent Police Investigative Directorate Complaints Procedure accessed from http://www.ipid.gov.za/node/4 on 6 June 2020.

58. Act 1 of 2011.

conduct independent and impartial investigations of allegations of criminal offences committed by members of the SAPS and the MPS, and to make appropriate recommendations.

The IPID is responsible for promoting proper police conduct in accordance with the principles of the Constitution. IPID investigates matters specified under section 28 of the IPID Act. The following matters fall within IPID's investigative mandate:

- 'any death in police custody;
- death as a result of police actions;
- any complaint relating to the discharge of an official firearm by any police officer;
- rape by a police officer, whether the police office is on or off duty;
- rape of any person while that person is in police custody;
- Any complaint of torture or assault against a police officer in the execution of his or her duties;
- Corruption matters with the police initiated by the Executive Director of IPID[59] on his or her own, or after the receipt of a complaint from a member of the public, or referred to the Directorate by the Minister, an MEC or the Secretary, as the case may be; and
- Any other matter referred to it as a result of a decision by the Executive Director, or if so requested by the Minister, an MEC or the Secretary as the case may be.'[60]

Any person, either as a victim, witness or representative and a non-governmental and community-based organization can lodge a complaint with the IPID.

A complaint may be lodged in person, by telephone, per letter or e-mail to any IPID office. The complainant must fill in a Complaint Reporting Form which can be obtained from any IPID office or downloaded from http://www.ipid.gov.za/sites/default/files/IPID_Complaints_Form-Form2.pdf

The IPID cannot deal with the following:

- Complaints of incidents which occurred before the establishment of the Independent Complaints Directorate (ICD) in April 1997 and those which took place more than a year before they were reported to the IPID, unless there are exceptional circumstances;
- Complaints against Correctional Services staff, court officials, and members of the South African National Defence Force;
- Matters that have been dealt with or are currently being dealt with by the courts; and
- Matters that are not criminal in nature, for example, divorce, recovery of money or unlawful arrest.

3.4.1.2. SAPS Service Complaint Centre

The SAPS Service Complaint Service Centre's aim is to investigate poor service by members of SAPS. In particular, the aim of the Service Complaint Service Centre is to redress and investigate dissatisfaction or disappointment experienced by any person or an organisation, locally, regionally, continentally, or internationally, in relation to an action or inaction regarding the service that was rendered or supposed to be rendered by the SAPS represented by its employee/s.

Complaints can lodged regarding poor service delivery in respect of the following issues:

- communication;
- responses;
- investigations;
- police negligence;
- police misconduct;
- complaints against any member of the SAPS management or members; and
- general comments.[61]

59. The Executive Director is appointed in terms of section 6 of the IPID Act. The Executive Director is the accounting officer of IPID. His or her duties are set out in detail in section 7 of the IPID Act.

60. Section 28(1)(a)-(h) of the IPID Act.

61. For more information on how to lodge a complaint with the SAPS Service Complaint Centre visit at https://www.saps.gov.za/services/service_complaints_centre.php.

There is minimum information which is required in order to lodge a complaint including, but not limited to

- full names and surname of the complainant;
- identity number;
- residential/business address; and
- telephone and cell phone numbers and email address.

Complainants must also provide a description of the complaint including

- the province in which the complaint originated;
- the name of the police station; the case number (if applicable); and
- details of the SAPS employees involved.

Complaints must be submitted directly by visiting any local police station, community service centre, Station Commander, District / Cluster Commander's office or Provincial Complaints Coordinators which is available at https://www.saps.gov.za/services/service_complaints_centre.php. Failing which, one can contact the National Service Complaints Call Centre on 0800 333 177 or fax to 012 393 5452 or email complaintsnodalpoint@saps.gov.za.

3.4.2. Denial of Access to Healthcare Due to Sex Work Status

If a sex worker is denied access to health or discriminated against by a healthcare provider they can lodge a complaint against health professional or a health establishment with the Health Professions Council of South Africa (HPCSA).

3.4.2.1. Complaints Against a Health Professional or Health Establishment

Section 18 of the National Health Act[62] makes provision for persons who would like to lodge a complaint against a health professional or healthcare establishment for the way they were treated to lay a complaint and to have that complaint investigated. It also states that the procedure for lodging complaints must be made visible in all health establishments in a place where all persons will see it.

3.4.2.2. Complaints to the Health Professionals Council of South Africa

The Health Professions Council of South Africa (HPCSA) is a statutory body established in terms of section 2(1) of the Health Professions Act.[63] One of the objectives of the HPCSA is to ensure the investigation of complaints concerning persons registered in terms of the [Health Professions Act] and ensure that appropriate disciplinary action is taken against such persons in terms of the [Health Professions Act]'.[64] The HPCSA outlines the process of lodging a complaint as follows:[65]

- Commence by lodging a complaint in writing which should be addressed to the Registrar, either online or by completing a complaint form[66] and emailing it to legalmed@hpcsa.co.za or by courier or hand delivery to 553 Madiba Street, Arcadia, Pretoria, 0001 or by post to PO Box 205, Pretoria, 001.

3.4.2.3. How to Lodge a Complaint to the HPCSA

The Procedural Regulations Pertaining to the Functioning of the Office of Health Standards Compliance and Handling of Complaints by the Ombud are regulations made by the Minister of Health which came into operation on 2 November 2016. According to the HPCSA an ombudsman is a person appointed by the Council to mediate in the case of minor transgressions referred to him or her by the Registrar for mediation.[67]

62. 61 0f 2003. Section 18 of the National Health Act provides as follows:
'(1) Any person may lay a complaint about the manner in which he or she was treated at a health establishment and have the complaint investigated.
(2) The relevant member of the Executive Council and every municipal member must establish a procedure for the laying of complaint within those areas of the national health system for which they are responsible.'

63. 56 of 1974.

64. Section 3(n) of the Health Professions Act.

65. The Healthcare Professionals Council of South Africa: Legal and Regulatory Affairs available at https://www.hpcsa.co.za/?contentId=452&actionName=Legal%20and%20Regulatory%20Affairs last accessed on 20 June 2020.

66. The HPCSA complaint form can be accessed at https://www.hpcsa.co.za/.uploads/UPDATED%202018%20COMPLAINT%20FORM%20LETTER.pdf.

67. Ibid

A complaint to the ombudsman can be laid in the following ways:

- Orally (including by telephone) or in writing, by email or other electronic means;
- The ombudsman must make sure to make record of the complaint and must confirm accuracy of complaint with complainant; and
- ombudsman must provide the complainant with reasonable assistance where necessary and ensure reasonable access to ombudsman is present to users of the healthcare system and other concerned persons.[68]

How to lodge a complaint relating to persons/entities other than a healthcare professional:

- If a complaint is related to a hospital, 'any person may lodge a complaint with the Office of Health Standards Compliance (OHSC)[69] for breach of any norms or standards by both public and private health establishments.
- If a complaint is related to a nurse, and if an individual feels that a nurse has acted negligently or unethically, individual nurses can be reported to the South African Nursing Council (SANC)[70] who will investigate the complaint; and
- If a complaint is related to \an alternative healthcare practitioner who has acted negligently or unethically, an individual may report the incident to the Allied Health Professions Council of South Africa (AHPCSA)[71] which will investigate their complaint.

68. The Procedural Regulations Pertaining to the Functioning of the Office of Health Standards Compliance and Handling of Complaints by the Ombud, section 33- How to lay a complaint.

69. For more information on the OHSC complaints procedure visit https://ohsc.org.za.

70. For more information on the SANC complaints procedure visit https://www.sanc.co.za/.complain_misconduct.htm.

71. For more information on the AHPCSA procedure visit https://ahpcsa.co.za/lodge-a-complaint/.

SUB-CHAPTER 4.6:
MEN WHO HAVE SEX WITH MEN

1. Introduction

1.1. Background

Men who have sex with men (MSM)[1] is a term created in the 1980s in the context of 'public health efforts to understand men's sexual behaviour as it relates to HIV transmission and prevention.'[2] MSM refers to men who self-identify as:[3]

- Gay, bisexual, or transgender;
- Heterosexual men who engage in sex with other men during incarceration, periods of homelessness, or for economic gain; and
- Men who have sex with women and/or transgender women whilst also having sex with males.

The existence of socio-cultural and religious beliefs that are deeply conservative, particularly concerning sex, marriage and children, give rise to a common but false portrayal of homosexuality as 'unAfrican'.[4] These prejudices can permeate politics and, in turn, lead to a delay in legal and policy changes that recognise and benefit MSM and other marginalised and vulnerable groups.

The South African legal framework is supportive of all sexual orientations and gender identities. Nonetheless, a key group stakeholder consultation process conducted in 2011 found that stigma and discrimination by healthcare workers towards MSM, was a major barrier in accessing health services.[5] A study conducted in Gauteng, found that 44% of the 487 lesbian, gay, bisexual or transgender study respondents reported having experienced heterosexism when accessing healthcare.[6]

1.2. Why are MSM Vulnerable to HIV?

The World Health Organisation (WHO) and the South African National Strategic Plan 2017 – 2022[7] identify MSM as one of the key groups vulnerable to Human Immunodeficiency Virus (HIV), Sexual Transmitted Infection (STI) and Tuberculosis (TB) infection alongside prisoners (inmates), drug users, sex workers and transgender people.[8] Various studies conducted in South Africa reveal that MSM engage in high-risk sexual behaviour and therefore are vulnerable to HIV.[9] Reports also reveal that high levels of stigma and discrimination by healthcare workers present barriers for this group to access healthcare services and sexual and reproductive services and to utilise available voluntary HIV testing and counselling services. MSM experience disapproval, rejection and sub-optimal services in healthcare settings to the point of their exclusion from the formal health system altogether which, to a large extent, results in less effort being placed on HIV prevention campaigns and research for MSM.[10] Generally, staff at health facilities

1. Men who have sex with men, is a term used describe 'men including those who do not identify themselves as homosexual or bisexual, who engage in sexual activity with other is used in the public health contexts to avoid excluding men who identify as heterosexual'. It is important in these circumstances to note that the use of this terminology in this chapter is used solely in order to bring it in line with the terminology used by the Department of Health and public health care in general. However, it should be noted that critics argue that the use of this terminology obscures social dimensions of sexuality and undermine the self-labelling of LGB individuals and fails to sufficiently describe variations in sexual behaviour. For more on this see Young "The Trouble With 'MSM' and 'WSW': Erasure of the Sexual-Minority Person in Public Health Discourse" (2005) *American Journal of Public Health* 1144.
2. Loue "Defining Men Who Have Sex With Men (MSM)" in Loue (ed) *Health Issues Confronting Minority Men Who Have Sex With Men* (Springer, New York 2008).
3. Ibid at 3.
4. Zahn "Human Rights Violations among Men who have Sex with Men in Southern Africa: Comparison between Legal Contexts" (14 January 2016) available at https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0147156.
5. Duby ''Scared of going to the clinic': Contextualising Healthcare Access for Men Who Have Sex With Men, Female Sex Workers and People Who Use Drugs in Two South African Cities" (2018) 19(1) *Southern African Journal of HIV Medicine* at 9.
6. Ibid. See also Polders L, Wells H. Overall research findings on levels of empowerment among LGBT people in Gauteng, South Africa. Unpublished report. Pretoria: Out LGBT Well-Being; 2004.
7. South Africa's National Strategic Plan for HIV, TB and STI 2017-2022 available at https://sanac.org.za//wp-content/uploads/2017/06/NSP_FullDocument_FINAL.pdf.
8. Ibid at 23.
9. Lane T, Mcintyre J., Morin S. High-risk sex among black MSM in South Africa: Results from the Gauteng MSM survey. 2006a. *Poster presented* at the XVI International AIDS Conference, Toronto, Canada, August 13–18, 2006 and Lane T., Mcintyre J., Morin S. HIV testing and stigma among Black South African MSM. 2006b. Poster presented at the International AIDS Conference, Toronto, Canada, August, 13–18 August, 2006.
10. Cloete "Stigma and Discrimination Experiences of HIV-Positive Men Who Have Sex With Men in Cape Town, South Africa" *AIDS Care* (29 September 2008) available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3320098/.

lack the knowledge and experience to address [MSM] specific health concerns and needs. Moreover, often the articulation of moral judgment and disapproval of [MSM] patients' identity and the forced subjection of patients to religious practices and lack of knowledge about MSM and health needs, leads to poor-quality care results especially with regard to HIV and STI prevention, treatment and care.

2. South African Law and MSM

2.1. Constitutional and Legislative Protection

The Interim Constitution which came into effect on 27 April 1994 and its successor the 1996 Constitution brought about the fundamental principle of 'constitutional supremacy'.[11] A Bill of Rights was put in place in the Constitution to protect human rights.

The Constitution explicitly prohibits discrimination based on sexual orientation. The Constitution provides for freedom from discrimination based on sexual orientation and the right to privacy. Section 9(3) provides that '[t]he state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth.' Section 14 provides that '[e]veryone has the right to privacy.'

The Promotion of Equality and Prevention of Unfair Discrimination Act[12] (PEPUDA) was enacted as a direct result of section 9, read with item 23(1) of Schedule 6, of the Constitution. The main objective of PEPUDA is to prevent and prohibit unfair discrimination, harassment and hate speech in almost every sphere of society.[13] Also referred to as the Equality Act, PEPUDA entrenches positive duties in respect of equality by calling on the State and all persons to promote substantive equality and designates all Magistrate's Courts and High Courts as Equality Courts for their area of jurisdiction to deal with violations of the rights to equality enshrined in section 9.

The Prevention and Combating of Hate Crimes and Hate Speech Bill,[14] if enacted, will recognise the notion of hate crimes and hate speech on grounds of race, gender identity and sexual orientation by imposing harsher sentences in instances where a crime is a hate crime. This legislation will regulate crimes that are motivated by religious and cultural prejudice which are committed based on an individual's race, nationality and sexual orientation.

2.2. Legality of Same-sex Sexual Activity

In line with the principle of constitutional supremacy, section 8 of the Constitution provides that the Bill of Rights applies to all laws and binds the legislature, the executive, the judiciary and all organs of state. The effect of this provision is that government may not enact laws that violate the rights of individuals. An Act of Parliament which limits or violates rights or freedoms could be struck down as contrary to the Bill of Rights.

Our courts through section 172(1) of the Constitution are given the power to declare invalid any law or conduct inconsistent with the Bill of Rights and the Constitution. The exercise of this power is demonstrated through decisions in which the criminalisation of same-sex sexual activity was declared unconstitutional after 1994, allowing for an open relationship between same sex couples. The following landmark cases decriminalised same-sex sexual activities in South Africa:

- In 1997 in the case of *S v Kampher*,[15] the High Court ruled that the common-law crime of sodomy was incompatible with the constitutional rights to equality and privacy.
- In 1999 in the case of *National Coalition for Gay and Lesbian Equality v Minister of Justice*,[16] the High Court ruled that the common-law crimes of sodomy and 'commission of an unnatural sexual act', as

11 'Constitutional Supremacy' is aptly described in section 2 of the Constitution of the Republic of South Africa, 1996 as follows: 'This Constitution is the supreme law of the Republic; law or conduct inconsistent with it is invalid, and the obligations imposed by it must be fulfilled.'

12. 4 of 2000.

13. Kok "The Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000: Proposals for Legislative Reform" (2008) 24 *South African Journal on Human Rights* 445. See also Sections 10, 11 and 24 of PEPUDA.

14. B9-2018 published in Government Gazette No. 41543 of 29 March 2018.

15. 1997 (2) SACR 418 (C).

16. 1998 (6) BCLR 726 (W).

well as Section 20A of the Sexual Offences Act,[17] were unconstitutional. The Constitutional Court[18] confirmed the High Court judgment which applied retroactively to acts committed since the adoption of the Interim Constitution in 1994.

- Despite the decriminalisation of sex between men, the age of consent set by the Sexual Offences Act was 19 for homosexual acts but only 16 for heterosexual acts. This was rectified in 2007 by the Criminal Law (Sexual Offences and Related Matters) Amendment Act,[19] which codified the law on sex offences in gender- and orientation-neutral terms and set 16 as the uniform age of consent. In 2008, even though the new law had come into effect, the former inequality was declared to be unconstitutional in the case of *Geldenhuys v National Director of Prosecution*,[20] which declared sections 14(1)(b) and 14(3)(b) of the Sexual Offences Act unconstitutional and invalid. These sections set the age of consent for sexual intercourse at 19 for same sex couples, while setting the age of consent at 16 for heterosexual couples.

3. Access to Healthcare Services

Section 27 of the Constitution guarantees everyone the right to access healthcare services. In addition, section 9(3) of the Constitution explicitly prohibits discrimination on the grounds of sexual orientation. Thus, South African healthcare workers are constitutionally and ethically obliged to provide MSM equitable, impartial medical care and treatment.

Policies that highlight the need for sensitisation training include the South African National Strategic Plan for HIV, TB and STIs (2017–2022),[21] the South African National LGBTI HIV Plan (2017–2022)[22] and the Operational Guidelines for HIV, STIs and TB Programmes for Key Populations in South Africa (2012).[23] These policies describe various ways in which the need for specific efforts to address judgmental attitudes amongst healthcare workers are to be made. These include providing healthcare workers with the skills to provide the necessary support, counselling and services to MSM even when there is marked conflict with personally held moral, heteronormative and prejudicial views.[24]

4. Legal Remedies

4.1. Remedies Against Healthcare Workers

If MSM are denied access to health or discriminated against by a healthcare provider, they can lay a complaint against a health professional or a health establishment.

4.1.1. Complaints Against a Health Professional or Healthcare Establishment

Section 18 of the National Health Act[25] provides that persons who would like to lay a complaint against a health professional or establishment, regarding the way they were treated have the right to lay a complaint and have the right to have that complaint investigated. It also states that this procedure must be made visible at all health establishments in a place where all persons will see it.

17. 23 of 1957.
18. 1999 (1) SA 6 (CC).
19. 32 of 2007.
20. 2009 (2) SA 310 (CC).
21. See South African National Strategic Plan for HIV, TB and STIs 2017-2022 above n6.
22. South African National LGBTI HIV Plan 2017-2022 available at https://sanac.org.za/wp-content/uploads/2017/06/LGBTI-HIV-Plan-Final.pdf.
23. National Department of Health "Operational Guidelines for HIV, STIs and TB Programmes for Key Populations in South Africa" (12 September 2012).
24. Duby ''Scared of going to the clinic': Contextualising Healthcare Access for Men Who Have Sex With Men, Female Sex Workers and People Who Use Drugs in Two South African Cities" (2018) 19(1) *Southern African Journal of HIV Medicine* at 9.
25. 61 0f 2003. Section 18 provides:
'(1) Any person may lay a complaint about the manner in which he or she was treated at a health establishment and have the complaint investigated.
(2) the relevant member of the Executive Council and every municipal member must establish a procedure for the laying of complaint within those areas of the national health system for which they are responsible.'

4.1.2. Complaints to the Health Professionals Council of South Africa

The Health Professions Council of South Africa is a statutory body established in terms of section 2(1) of the Health Professions Act.[26] One of the objectives of the HPCSA is to ensure the investigation of complaints concerning persons registered in terms of the [Health Professions Act] and ensure that appropriate disciplinary action is taken against such persons in terms of the [Health Professions Act]'.[27] The HPCSA outlines the process of lodging a complaint as follows:[28]

- Commence by lodging a complaint in writing which should be addressed to the Registrar, either online or by completing a complaint form[29] and emailing it to legalmed@hpcsa.co.za or by courier or hand deliver to 553 Madiba Street, Arcadia, Pretoria, 0001 or by post to PO Box 205, Pretoria, 001.

4.1.3. How to Lodge a Complaint to the HPCSA

The Procedural Regulations Pertaining to the Functioning of the Office of Health Standards Compliance and Handling of Complaints by the Ombudsman are regulations made by the Minister of Health which came into operation on the 2 November 2016. According to the HPCSA, an ombudsman is a person appointed by the council to mediate in the case of minor transgressions referred to him or her by the Registrar for mediation.[30]

A complaint to the ombudsman can be laid in the following ways:

- Orally (including by telephone) or in writing, by email or other electronic means;
- The ombudsman must make sure to make record of the complaint and must confirm the accuracy of complaint with complainant;
- The ombudsman must provide the complainant with reasonable assistance where necessary and ensure reasonable access to ombudsman is present to users of the healthcare system and other concerned persons.

How to lodge a complaint relating to persons/entities other than a healthcare professional:

- If a complaint is related to a hospital, 'any person may lodge a complaint with the Office of Health Standards Compliance (OHSC)[31] for breach of any norms or standards by both public and private health establishments';
- If a complaint is related to a nurse's negligent or unethical conduct, 'individual nurses can be reported to the South African Nursing Council (SANC)[32] to investigate the complaint'; and
- If a complaint is related to an alternative healthcare practitioner's negligent or unethical conduct complaints can be reported to the Allied Health Professions Council of South Africa (AHPCSA)[33] to investigate the complaint.

26. 56 of 1974.
27. Section 3(n) of the Health Professions Act.
28. The Healthcare Professionals Council of South Africa: Legal and Regulatory Affairs available at https://www.hpcsa.co.za/?contentId=452&actionName=Legal%20and%20Regulatory%20Affairs last accessed on 20 June 2020.
29. The HPCSA complaint form can be accessed at https://www.hpcsa.co.za/.uploads/UPDATED%202018%20COMPLAINT%20FORM%20LETTER.pdf.
30. See above n27.
31. For more information on the OHSC complaints procedure visit https://ohsc.org.za.
32. For more information on the SANC complaints procedure visit https://www.sanc.co.za/.complain_misconduct.htm.
33. For more information on the AHPCSA procedure visit https://ahpcsa.co.za/lodge-a-complaint/.

SUB-CHAPTER 4.7: PEOPLE WHO INJECT DRUGS

1. Introduction

1.1. Contextual Background

The regulation of drugs and drug use, commonly known as the "War on Drugs" can be traced back to the 1960's where the United Nations Member States ratified three major conventions[1] that have fuelled criminal and repressive approaches to many forms of drug use. Globally, the War on Drugs has become a conflict of enforcing prohibitionist policies on the manufacture, distribution, and consumption of 'illegal drugs.'[2] In recent years, the War on Drugs has evolved with a recognition that this approach has created a 'militaristic approach' to a public health problem and has not only perpetuated, 'but fuelled, severe human rights abuses towards people who use drugs and those who inject drugs.' Therefore, it 'was not effective in its stated goals to curb drug use, and but only worsened public health issues, especially in the context of [Human Immunodeficiency Virus] HIV'.[3]

Stimulant drug use and non-injecting and injecting of drugs, has been associated with the sexual transmission of HIV, particularly among men who have sex with men and sex workers. Globally, it is acknowledged that harm reduction strategies are an effective way of curbing HIV and possibly other blood-borne viruses within People Who Inject Drugs (PWID). In addition, it is acknowledged that this vulnerable population needs a complete package of health and social services, including, policies and approaches that address the harms of illicit drug use and drug policy.[4] A report released by UNAIDS on 13 March 2019, shows that 'despite a decline in new HIV infections globally, HIV incidences are not declining among PWID. The report also indicates that 99% of PWID live in countries that do not provide adequate harm reduction service coverage.[5]

The consequences of the War on Drugs on public health is that people who use drugs and inject drugs:[6]

- Are highly stigmatised and discriminated against, and are often unable or unwilling to access healthcare for fear of arrest or harassment;
- face numerous barriers to accessing effective healthcare and treatment;[7] and
- Are over represented in prisons with low access to health and social welfare services.

Prohibitive drug laws that do not encourage harm reduction strategies leave healthcare workers unprepared to manage the unique healthcare needs of PWID.

South Africa's National Strategic Plan on HIV, TB and STIs (2017–2022), ,recognises PWID as key vulnerable populations for HIV and Sexual Transmitted Infections (STI's), and calls for immediate attention to increasing access to healthcare services and harm reduction programmes for this population.

1.2. Why are People Who Inject Drugs Vulnerable to HIV?

People who inject drugs are more at risk of contracting HIV than the general population, for the following reasons:

- **Sharing needles:** People who inject drugs often share needles. If a needle has been used by an HIV-positive person, infected blood in the needle can be injected into the next person who uses that needle. Moreover, injecting drug users are more likely to delay testing for HIV, increasing the chance of onward HIV transmission[8].

1. The United Nations Single Convention on Narcotics Drugs (1961); The United Nations Convention on Psychotropic Substances (1971) (as amended by the 1972 Protocol Amending the Single Convention); The United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychoactive Substances (1988).
2. AIDS and Rights Alliance for Southern Africa" Drug Policy and the Lived Experiences of People Who Use Drugs in Southern Africa" (2019) available at www.arasa.info at 3 last accessed on 13 May 2020.
3. Ibid at 3.
4. Ibid at 23.
5. UNAIDS 'Promises to improve health outcomes for people who inject drugs remain unfulfilled as 99% do not have adequate access to harm reduction services' available at https://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2019/march/20190313_drugs_report last accessed on 17 May 2020.
6 Ibid at 7.
7. Benjamin et al *People Who Inject Drugs and Other People Who Use Drugs – An Introductory Manual for Health Care Workers in South Africa* 1 ed (2012) available at http://desmondtutuhivfoundation.org.za/wp-content/uploads/2018/11/DTHF-manual-People-Who-Inject-Drugs.pdf last accessed on 17 May 2020.
8. Avert 'People Who Inject Drugs, HIV and AIDS' available https://www.avert.org/professionals/hiv-social-issues/key-affected-populations/people-inject-drugs#HIV%20prevention%20for%20people%20who%20inject%20drugs last accessed on 20 June 2020.

- **Criminalisation and marginalisation:** Legislation that criminalises the possession and use of drugs for personal consumption leads to more risky forms of drug use. Along with other punitive policies and practices which discriminate against people with a history of drug use, criminalisation reinforces the marginalisation of people who inject drugs while also discouraging them from accessing harm reduction and other healthcare services. This largely increases vulnerability to HIV infection, and has a negative effect on HIV prevention and treatment outcomes.[9]
- **Stigma and Discrimination:** The first reason that PWID experience stigma is because the primary characteristic that describes PWID – the fact that they use drugs – is seen as deviant and is illegal in South Africa.

1.3. Criminalisation of Drug Use and Human Rights Violations

Drugs are criminalised in South Africa.[10] As a result, arbitrary police arrest, police corruption and violations of human rights without any access to justice is a daily occurrence against this population.[11] The rights violations reported by PWID against the South African Police Service operating with impunity include:

- 'being stopped and searched without cause;
- being detained and searched with excessive violence;
- being beaten;
- being stripped naked and searched in the street;
- being held until they were in opiate withdrawals or craving drugs in order to extract a confession or bribe;
- being threatened and intimidated with a gun; and
- having a plastic held over the face so they could not breath during interrogation.'[12]

This situation is exacerbated by the punitive approach adopted by the Drugs and Drugs Trafficking Act[13] which prescribes a sentence up to 25 years for production[14] and encourages arrest rates in order to measure police performance on drug arrests. In 2019, police were required to increase the number of arrests for drug possession by 47.36%. This approach has reinforced police actions that may be ineffective, divisive or predatory.

2. The Legal and Policy Environment on Drugs and Drug Use in South Africa

Drug use is common in South Africa and the practice of injection drug use is increasing. However, for many, including healthcare workers it still remains an unfamiliar topic. South Africa is a signatory to the three international Conventions on drug use.[15] In South Africa drugs are defined and legislated through three Acts:

- The Medicine and Related Substance Act[16] which defines the scheduling of drugs and describes the legal and illegal use of substances.
- The Drugs and Drugs Trafficking Act[17] which defines illegal acts relating to substances, and covers penalties for drug use or possession and law-enforcement roles and processes. This Act is 'notably reactive, punitive, and prohibitionist.'[18]
- The Prevention of and Treatment for Substance Abuse Act[19] which outlines the broader social and legislative response to substance use with emphasis on the responsibilities of the Department of Social Development.

9. Ibid
10. The Drug and Drug Trafficking Act 140 of 1992, prohibits the use or possession of or the dealing in drugs.
11. The National Drug Master Plan (2013–2017) available at https://www.gov.za/sites/default/files/gcis_document/201409/national-drug-master-plan2013-17.pdf. last accessed on 4 November 2020 at 22.
12. Ibid at 23.
13. 140 of 1992.
14. Section 17(e) read with section 13(f) of the Drug and Drug Trafficking Act.
15. See above n1.
16. Act 101 of 1965
17. Act 140 of 1992
18. Scheibe *et al* "Safe treatment and treatment of safety: call for a harm-reduction approach to drug-use disorders in South Africa" (2017) 1 *South African Health Review* 197 at 199.
19. 70 of 2008.

The legislation adopts a zero tolerance approach on drugs and drug use. The South African War on Drugs is categorised as a war on people who use and inject drugs and thus not 'upon the development of appropriate rehabilitative models, but upon prevention, prohibition and punishment'.[20] The result of this approach is, PWID are subjected to serious stigmatisation, marginalisation and social exclusion which prevents them from recovery by hindering their re-integration into the wider social and economic community.[21]

2.1. Constitutional Protections and Drug Policy Reform

2.1.1. Constitutional Protections

Section 9 of the Constitution, read with the Promotion of Equality and Prevention of Unfair Discrimination Act (PEPUDA),[22] prohibits unfair discrimination on the grounds of race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture and language and 'other grounds'. Through the interpretation of reference to 'other grounds' in Section 9, the Constitutional Court has recognised new grounds on which discrimination can occur.[23] Therefore, an argument can be made to the effect that the impact of prohibitive measures imposed against PWID, for example includes:

1. No recourse to justice or redress within the law for them;
2. Their vulnerability to corruption and violence by police; and
3. Sexual exploitation violate their rights to equality, the right to freedom and security[24] of the persons and the right to human dignity.[25]

In *Minister of Justice and Constitutional Development and Others v Prince (Clarke and Others Intervening); National Director of Public Prosecutions and Others v Rubin; National Director of Public Prosecutions and Others v Acton*[26] the Constitutional Court had to determine whether sections 4(b) and 5(b) of Drugs and Drug Trafficking Act read with Part III of Schedule 2 of that Act and section 22A(9)(a)(1) of the Medicines and Related Substances Control Act was inconsistent with section 14 of the Constitution to the extent that both Acts criminalise the use or possession in private or cultivation in a private place of cannabis by an adult for his or her own personal consumption in private. The Court held that the criminal prohibition, use or cultivation of cannabis by an adult person for personal consumption in private is an infringement of the right to privacy of an adult person and constitutionally invalid. The State was directed to change the law to reflect this ruling within twenty-four months. This case effectively led to the decriminalisation of the possession and cultivation cannabis in private by adults for personal use. In essence, the effect of the judgment is two-fold: (a) it decriminalises the use or possession of cannabis by an adult in private for that adult person's personal consumption in private; and (b) it decriminalises the cultivation of cannabis by an adult in a private place for that adult's personal consumption in private. However, the use or possession of cannabis by a child anywhere, or by an adult in public, is not decriminalised.

20. Buchanan and Young *'The War on Drugs – A War on Drug Users'* 2000 available at https://glyndwr.repository.guildhe.ac.uk/257/ last accessed on 4 November 2020.

21. Scheibe "Injecting Drug use in South(ern) Africa 2018 (TBHIVCARE)" available at https://www.sahivsoc2018.co.za/wp-content/uploads/2018/11/13C_Andrew-Scheibe_PWID-in-Southern-Africa-SAHCS-18.pdf last accessed on 3 June 2020.

22. 4 of 2000.

23. Section 7(1) of the Constitution provides that
'[t]he Bill of Rights is a cornerstone of democracy in South Africa. It enshrines the rights of all people in our country and affirms the democratic values of human dignity, equality and freedom' (emphasis added).

24. Section 12 (1) provides that –
'Everyone has the right to freedom and security of the person, which includes the right—
(a) not to be deprived of freedom arbitrarily or without just cause;
(b) not to be detained without trial;
(c) to be free from all forms of violence from either public or private sources;
(d) not to be tortured in any way; and
(e) not to be treated or punished in a cruel, inhuman or degrading way.'

25. Section 10 of the Constitution states that 'Everyone has inherent dignity and the right to have their dignity respected and protected.'

26. 2018 (6) SA 393 (CC).

2.1.2. Drug Policy Reform

The National Drug Master Plan (2013–2017) (NDMP),[27] is a plan that seeks to provide a holistic approach to drug regulation, treatment and prevention. The Plan introduces a 'local definition of harm reduction, namely, 'limiting or ameliorating the damage caused to individuals or communities who have already succumbed to the temptation of substance abuse'.[28] It also seeks to align public-health and public-safety interests. However, the plan's approach that 'individual drug users are the problem, rather than the context they exist within' has been criticised as reinforcing the continuation of a prohibitionist criminal-justice approach.

South Africa also established the Central Drug Authority (CDA) which comprises of 18 national government departments, three other government bodies and 13 drug experts. The CDA reports to the Inter-Ministerial Committee on Substance Abuse. It is also informed by Provincial Substance Abuse Forums that in turn are informed by and support Local Drug Action Committees. The CDA is, among others, required to oversee the implementation and evaluation of the NDMP. However, the CDA has limited power, a negligible budget and little oversight capacity.[29] As a result, there has been minimal improvement on drug policy regulation in South Africa. However, it is important to note and be aware of the CDA and the revised NDMP on drug reform in South Africa.

3. Access to Healthcare for People Who Inject Drugs

3.1. Access to Healthcare

Even though injection drug use is illegal in South Africa, it is not illegal to provide healthcare services to PWID. Reports have shown that PWID experience very poor care when they do disclose their injecting drug use to healthcare workers. PWID have reported situations where healthcare workers refused them treatment, provided them with inadequate treatment, and/or made very abusive remarks to them when they discover or even suspect that a patient is a PWID. Other healthcare workers see people who use or inject drugs as immoral and as sinners who are to blame for their own HIV infection and are therefore less deserving of healthcare.

Section 27 of the Constitution states that 'everyone has the right to access healthcare services' and that 'no one may be refused emergency medical treatment'. Other parts of the Constitution more broadly address PWID's right to access care. For example, Section 10 states that 'everyone has the inherent dignity and the right to have their dignity respected and protected'. PWID and their right to access care are further protected by the National Health Act[30], which more broadly promotes the right of everyone to access medical treatment.

It is every healthcare worker's duty to provide PWID the same care and treatment that they provide to other patients. Healthcare workers may have personal beliefs that make providing care to PWID challenging for them. However, it is important, though, that healthcare workers see all PWID as people deserving equal and fair treatment and not as powerless victims or irresponsible criminals.

Healthcare providers are not required to report to the police if a patient discloses that he or she injects drugs. South African law does, however, require anyone to report to the police if they personally come in contact with heroin, which is an illegal substance. In a healthcare setting, this would only apply if a patient brought heroin with them to the clinic.

3.2. Harm Reduction Measures

Harm reduction is a public health strategy that was initially developed for adults with substance abuse problems for whom abstinence was not feasible.[31] Harm reduction approaches have been effective in reducing morbidity and mortality in these adult populations. International guidelines support the use of policies, programmes and approaches that work to reduce the health, social, and economic risks associated with the use of drugs. This is also known as harm reduction. Harm reduction strategies support PWID, in helping them to find ways to engage in their behaviour more safely. Recommended interventions on harm reductions include:

27. See the National Drug Master Plan (2013–2017) above n11 available at https://www.gov.za/sites/default/files/gcis_document/201409/national-drug-master-plan2013-17.pdf. last accessed on 4 November 2020.
28. Ibid at 200.
29. Ibid
30. 61 of 2003.
31. Harm reduction: An approach to reducing risky health behaviours in adolescents. (2008). *Paediatrics & child health*, 13(1), 53–60 at 53 accessed from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2528824/ on 5 November 2020.

- free access to treatment services for disadvantaged groups;
- expanding the number of treatment centres, especially into rural areas;
- increase support groups;
- appointing skilled staff, including occupational therapists, nurses, social workers and counsellors to help substance abusers in treatment centres;
- surveillance for HIV/hepatitis B/C among drug users in treatment is required;
- mobilise the community by educating them about the dangers of substance abuse;
- in-patient treatment facilities should be coupled with good after care facilities;
- more infrastructure, such as buildings, are needed for current treatment centres to be able to expand into;
- needle and syringe exchange programmes are required, in order to provide clean equipment to PWID and/or assist them in properly discarding their used equipment;
- provide opioid substitution therapy and other drug dependence treatments;
- provide targeted information, education, and communication for PWID and their sexual partners. This information should be directed specifically at PWID and include details on HIV and STI prevention, as well as harm-reduction strategies and other methods of safe injection; and
- prevention, diagnosis, and treatment of TB. Often, PWID are exposed to other factors that expose them to TB, such as imprisonment. All PWID should be screened for TB and treated as per standard protocols.[32]

These recommendations are supported and outlined in the South African National Strategic Plan 2017-2022.[33]

4. Remedies

4.1 Remedies Against Police Impunity

As demonstrated above, PWID are currently left outside of constitutional and legal protections due to severe drug control regulations that continue to increase systemic and institutional discrimination, corruption and rights violations against them.[34] However, PWID or anyone acting on their behalf can lodge a complaint against corrupt police officers that continue to harass PWID and violate their rights.

4.1.2. Independent Police Investigative Directorate (IPID)[35]

The IPID was established by the Independent Police Investigative Directorate Act[36] in line with the section 205 208 of the Constitution which seeks to regulate policing in South Africa. The aim of IPID is to ensure independent oversight over SAPS and the Municipal Police Services (MPS), and to conduct independent and impartial investigations of identified criminal offences allegedly committed by members of the SAPS and the MPS, and make appropriate recommendations.

The IPID is responsible for promoting proper police conduct in accordance with the principles of the Constitution. IPID investigates matters specified under section 28 of the IPID Act. The following matters fall within IPID's investigative mandate:

- 'any death in police custody;
- death as a result of police actions;
- any complaint relating to the discharge of an official firearm by any police officer;
- rape by a police officer, whether the police office is on or off duty;
- rape of any person while that person is in police custody;
- any complaint of torture or assault against a police officer in the execution of his or her duties;

32. South Africa's National Strategic Plan For HIV, TB and STIs 2017 -2022 available at https://sanac.org.za//wp-content/uploads/2017/06/NSP_FullDocument_FINAL.pdf.

33. Ibid.

34. See above n2 at 23.

35 Independent Police Investigative Directorate Complaints Procedure available http://www.ipid.gov.za/node/4 last accessed on 6 June 2020.

36. 1 of 2011.

- may investigate corruption matters with the police initiated by the Executive Director[37] on his or her own, or after the receipt of a complaint from a member of the public, or referred to the Directorate by the Minister, an MEC or the Secretary of the Police, as the case may be; and
- any other matter referred to it as a result of a decision by the Executive Director, or of so requested by the Minister, an MEC or the Secretary of Police as the case may be'. [38]

Any person, either as a victim, witness or representative and a non-governmental and community-based organisations can lodge a complaint with IPID.

A complaint may be lodged in person, by telephone, per letter or e-mail to any IPID office. The complainant must fill in a Complaint Reporting Form which can be obtained from any IPID office or downloaded from http://www.ipid.gov.za/sites/default/files/IPID_Complaints_Form-Form2.pdf

The IPID's investigative mandate does not extend to the following:

- complaints of incidents which occurred before the establishment of the Independent Complaints Directorate (ICD) in April 1997 and those which took place more than a year before they were reported to the IPID, unless there are exceptional circumstances;
- complaints against Correctional Services staff, court officials, and members of the South African National Defence Force;
- matters that have been dealt with or are currently being dealt with by the courts; and
- matters that are not criminal in nature, for example, divorce, recovery of money or unlawful arrest.

4.1.2. SAPS Service Complaint Centre

The SAPS Service Complaint Service Centres are established to investigate poor service by a member of SAPS. The aim of the process is to redress and investigate dissatisfaction or disappointment experienced by any person or an organisation, locally, regionally, continentally, or internationally, in relation to action or inaction regarding the service that was rendered or supposed to be rendered by the SAPS represented by its employee/s.

Complaints with the SAPS Service Complaint Centre can lodged in respect of for poor service delivery with regard to the following issues:

- communication;
- responses;
- investigations;
- police negligence;
- police misconduct; and
- complaints against the SAPS Management or members; and
- general comments.[39]

The minimum complaint information required to lodge a complaint includes, but is not limited to the following:

- full names and surname of the complainant;
- Identity number;
- residential/business address,
- telephone and cell phone numbers; and
- email address.

Complaints must also provide a description of the complaint including-

- the province in which the complaint originated;
- the name of the police station;
- the case number (if applicable); and
- details of the SAPS employees involved.

Complainants are submitted directly by visiting your local police station community service centre, Station Commander, District / Cluster Commander's office or Provincial Complaints Coordinators: Inspectorate of which are available https://www.saps.gov.za/services/service_complaints_centre.php. Failing which, you can contact the National Service Complaints Call Centre on 0800 333 177 or fax to 012 393 5452 or Email complaintsnodalpoint@saps.gov.za

4.2. Remedies Against Healthcare Workers

If PWID are denied access to health or discriminated against by a healthcare provider they can lay a complaint against a health professional or a healthcare establishment.

37. The Executive Director is appointed in terms of section 6 of the IPID Act. The Executive Director is the accounting officer of IPID. His or her duties are set out in detail in section 7 of the IPID Act.

38. Section 28(1)(a)-(h) of the IPID Act.

39. For more information on how to lodge a complaint with the SAPS Service Complaint Centre visit at https://www.saps.gov.za/services/service_complaints_centre.php.

4.2.1. Complaints Against a Health Professional or Health Establishment

Section 18 of the National Health Act[40] provides for persons who would like to lay a complaint against a health professional or establishment for the way they were treated have the right to lay a complaint and have the right to have that complaint investigated. It also states that this procedure must be made visible at all healthcare establishments in a place where all persons will see it.

4.2.1.1. Complaints to the Health Professionals Council of South Africa

The Health Professionals Council of South Africa (HPCSA) is a 'self-regulatory body which has an internal complaint mechanism whereby one can lodge a complaint when the guidelines have been violated by registered healthcare practitioner'.[41] The HPCSA provides that the process of lodging a complaint is the following:[42]

- Commence by lodging a complaint in writing and should be addressed to the Registrar, either online or by completing a complaint form[43] and emailing it to legalmed@hpcsa.co.za or by courier or hand delivery to 553 Madiba Street, Arcadi, Pretoria, 0001 or by post to PO Box 205, Pretoria, 001.

4.2.1.2. How to Lodge a Complaint to the HPCSA

The Procedural Regulations Pertaining to the Functioning of the Office of Health Standards Compliance and Handling of Complaints by the Ombud are regulations made by the Minister of Health which came into operation on 2 November 2016. According to the Healthcare Professionals Council of South Africa (HPCSA), an ombud or ombudsman is a person appointed by the council to mediate in the case of minor transgressions referred to him or her by the Registrar for mediation.[44]

A complaint to the ombud can be laid in the following ways:

- Orally (including by telephone) or in writing, by email or other electronic means.
- The Ombudsman must make sure to make record of the complaint and must confirm accuracy of complaint with complainant.
- Ombudsman must provide the complainant with reasonable assistance where necessary and ensure reasonable access to ombudsman is present to users of the healthcare system and other concerned persons.[45]

How to lodge a complaint relating to persons/entities other than a healthcare professional:

- If a complaint is related to a hospital, 'Any person may lodge a complaint with the Office of Health Standards Compliance (OHSC)[46] for breach of any norms or standards by both public and private health establishments.
- If a complaint is related to a nurse, 'If you feel that a nurse acted negligently or unethically, individual nurses can be reported to the South African Nursing Council (SANC)[47] to investigate the complaint; and
- If a complaint is related to 'an alternative healthcare practitioner, that is, an alternative healthcare practitioner acted negligently or unethically, report to the Allied Health Professions Council of South Africa (AHPCSA)[48] to investigate the complaint'.

40. 61 0f 2003. Section 18 provides
    (1) Any person may lay a complaint about the manner in which he or she was treated at a health establishment and have the complaint investigated.
    (2) the relevant member of the Executive Council and every municipal member must establish a procedure for the laying of complaint within those areas of the national health system for which they are responsible.
41. The Healthcare Professionals Council of South Africa: Legal and Regulatory Affairs available at https://www.hpcsa.co.za/?contentId =452&actionName=Legal%20and%20Regulatory%20Affairs.
42. Ibid.
43. The HPCSA complaint form can be accessed at https://www.hpcsa.co.za/.uploads/UPDATED%202018%20COMPLAINT%20 FORM%20LETTER.pdf.
44. Ibid.
45. The Procedural Regulations Pertaining to the Functioning of the Office of Health Standards Compliance and Handling of Complaints by the Ombud, s33 - How to lay a complaint.
46. For more information on the OHSC complaints procedure visit https://ohsc.org.za.
47. For more information on the SANC complaints procedure visit https://www.sanc.co.za/.complain_misconduct.htm.
48. For more information on the AHPCSA procedure visit https://ahpcsa.co.za/lodge-a-complaint/.

CHAPTER 5

GENDER-BASED VIOLENCE

1. Introduction

1.1. What is Violence?

The World Health Organisation (WHO) defines violence as the 'intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, which either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation.'[1] Research shows that violence results in 1.6 million fatalities each year making it a leading cause of death world-wide.[2] Physical violence is a type of violence that is common. This category of violence includes sexual violence, psychological violence and neglect.[3]

1.2. Defining Gender and Gender-based Violence

Gender can be defined as 'either of the two sexes (male and female), especially when considered with reference to social and cultural differences rather than biological ones. The term is also used more broadly to denote a range of identities that do not correspond to established ideas of male and female'.[4] Gender-based Violence (GBV) has many definitions which have evolved over the years. Broadly, it is defined as violence that occurs as 'a result of the normative role expectations associated with each gender, along with the unequal power relationships between […] genders, within the context of a specific society.'[5] Violence may be physical, sexual, psychological, economic or sociocultural. Globally, it has been observed that most acts of GBV are perpetrated by men on women and girls.

GBV also disproportionately affects women and girls.[6] It is 'systemic, and deeply entrenched in institutions, cultures and traditions.'[7] It manifests itself in social and cultural systems and structures such as patriarchy where 'male leadership is seen as the norm, and men hold the majority of power.' Patriarchy has evolved as a 'social and political system that treats men as superior to women – where women cannot protect their bodies, meet their basic needs, participate fully in society and men perpetrate violence against women with impunity'[8]

- **Psychological violence** is defined by the WHO as psychosomatic violence (e.g. emotional or psychological abuse) such as 'insults, belittling, constant humiliation, intimidation (e.g. destroying things), threats of harm, threats to take away children', while controlling behaviour is defined as 'isolating a person from family and friends; monitoring their movements; and restricting access to financial resources, employment, education or medical care.'[9]
- **Economic violence** is usually associated with Intimate Partner Violence (IPV) where the violent partner controls his or her partner's finances to prevent them from accessing resources, working or maintaining control of earnings, achieving self-sufficiency, and gaining financial independence.[10] This also includes interference with or preventing education, job training, and the ability to find and keep a job.
- **Sociocultural violence** is 'Cultural violence' that is defined here as any aspect of a culture that can be used to legitimize violence in its direct or structural form, which can be linked to patriarchy and other harmful cultural practices.[11]

1. World report on violence and health. Geneva, World Health Organization, 2002.
2. SaferSpaces ' What is Violence' accessed from https://www.saferspaces.org.za/understand/entry/what-is-violence on 30 March 2020.
3. Ibid: Physical violence is the intentional use of physical force, used with the potential for causing harm, injury, disability or death. This includes, but is not limited to: scratching, pushing, shoving, grabbing, biting, choking, shaking, slapping, punching, hitting, burning, use of a weapon, and use of restraint or one's body against another person leading not only physical harm but other psychological effects.
4. See www.dictionary.com
5 Bloom, Shelah S. 2008. "Violence Against Women and Girls: A Compendium of Monitoring and Evaluation Indicators." Carolina Population Center, MEASURE Evaluation, Chapel Hill, North Carolina. https://www.measureevaluation.org/resources/publications/ms-08-30
6 *Director of Public Prosecutions, Grahamstown v T M* (131/2019) [2020] ZASCA 5 (12 March 2020) para 15.
7. Op cit note 2
8. Ibid: see also Sultana, Abeda, Patriarchy and Women's Subordination: A Theoretical Analysis, The Arts Faculty Journal, July 2010-June 2011 accessed from http://www.bdresearch.org/home/attachments/article/nArt/A5_12929-47213-1-PB.pdf on 4 April 2020.
9. World Health Organization. Understanding and addressing violence against women: 2012. Retrieved from: http://apps.who.int/iris/bitstream/handle/10665/77432/WHO_RHR_12.36_eng.pdf?sequence=1.
10. National Coalition Agianst Domestic Violence: http://www.mmgconnect.com/projects/userfiles/File/DCE-STOP_NOW/NCADV_Economic_Abuse_Fact_Sheet.pdf
11. Galtung, J. Cultural Studies. Sage, 1990

Although GBV is largely viewed as violence against women, it also encompasses those individuals who do not conform to mainstream definitions of masculinity and femininity in society. For example, lesbian, gay, bisexual, transgendered and intersexed (LGBTI) persons are often victimised based on their sexual preferences that diverge from dominant gender-based roles.[12] This leads to expansion of the definition to GBV being violence that is directed at an individual based on his or her biological sex or gender identity.[13]

1.3. Forms of Gender-based Violence

GBV can be physical, sexual, emotional, financial or structural, and can be perpetrated by intimate partners, acquaintances, strangers and institutions. Most acts of interpersonal gender-based violence are committed by men against women, and the man perpetrating the violence is often known by the woman, such as a partner or family member.[14]

The following are the different forms of violence related to gender, in the context of how each gender is situated and treated in society:[15]

- **Violence against women and girls:** This is violence directed to women and girls.
- **Violence against LGBTI persons:** LGBTI persons experience gender-based violence because they are seen by society as not conforming to their assigned gender roles.
- **Intimate partner violence (IPV):** IPV is the most common form of GBV which includes physical, sexual, and emotional abuse and controlling behaviours by a current or former intimate partner or spouse, and can occur in heterosexual or same-sex couples.
- **Domestic violence (DV):** DV refers to violence which is carried out by partners or family members. DV can include IPV, but also encompasses violence against children or other family members.
- **Sexual violence (SV):** SV is 'any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work.'
- **Indirect (structural) violence:** is 'where violence is built into structures, appearing as unequal power relations and, consequently, as unequal opportunities. It exists when certain groups, classes, genders or nationalities have privileged access to goods, resources and opportunities over others, and when this unequal advantage is built into the social, political and economic systems that govern their lives.'

1.4. The impact of Gender-based Violence

GBV is a profound human rights violation with major social and developmental impacts for survivors of violence, as well as their families, communities and society more broadly. On an individual level, GBV leads to psychological trauma, and can have psychological, behavioural and physical consequences for survivors. In many parts of the country, there is poor access to formal psycho-social or even medical support, which means that many survivors are unable to access the help they need.

The following are the impacts of GBV and their effects on health, socio-economic and reproductive health rights:[16]

- South African healthcare facilities – an estimated 1.75 million people annually seek healthcare for injuries resulting from violence. This number continues to increase each year.

12. Tshikululu Social Investments 'Reframing interventions to end gender-based violence in South Africa: Lessons learnt from CSI-funded programmes', FirstRand Foundation Research Report (2014), http://www.tshikululu.org.za/uploads/files/FR_CSI_that_Works_GBV_Research_Report_final_Feb_2014.pdf, at p. 5See also EG Krug, LL Dahlberg, JA Mercy, AB Zwi and R Lozano (eds) World Report on Violence and Health (Geneva: World Health Organisation, 2002).
13. https://www.womenforwomen.org/blogs/series-what-does-mean-gender-based-violence
14. World Health Organisation, 2005, WHO multi-country study on women's health and domestic violence against women. REPORT - Initial results on prevalence, health outcomes and women's responses http://www.who.int/reproductivehealth/publications/violence/24159358X/en/
15. Op cit note 2.
16. Jewkes, R., et al. Preventing Rape and Violence in South Africa: Call for Leadership in A New Agenda For Action. MRC Policy Brief, 2009.

- HIV – an estimated 16% of all HIV infections in women could be prevented if women had not experienced domestic violence from their partners. Men who have been raped have a long term increased risk of acquiring HIV and are at risk of alcohol abuse, depression and suicide.
- Reproductive health – women who have been raped are at risk of unwanted pregnancy, HIV and other sexually transmitted infections.
- Mental health – over a third of women who have been raped develop post-traumatic stress disorder, which if untreated persists in the long term and depression, suicidality and substance abuse are common. As stated above, men who have been raped are at risk of alcohol abuse, depression and suicide.
- Criminal justice system – the South African Police Services is unable to deal with a number of GBV cases reported which means that access to justice is denied for many of the survivors of this violence.

Violence also has huge economic consequences. A 2014 study by KPMG estimated that in the year 2012/2013, GBV, and in particular violence against women, cost the South African economy between R28.4 billion and R42.4 billion, or between 0.9% and 1.3% of gross domestic product.[17]

2. Link between Gender-based Violence and HIV

2.1. Indirect (Structural) Violence

The relationship between gender and equality and the spread of HIV is the result of a 'complex interaction' of factors including the economic dependence of women on men; the survival strategies of women such as intergenerational sex, commercial sex work, and early marriage in conditions of poverty; the use of contraception; and historical and cultural gender traditions and attitudes that shape the sexual behaviour of men and women.[18] Gender relations, power imbalances, harmful social gender norms, violence against women and marginalisation of women all serve to increase women's vulnerability to HIV infection.[19] Women's increased biological vulnerability[20] is compounded by their subordinate social status.

Numerous studies also demonstrate that partner violence increases the risk of HIV infection.[21] Women who are beaten or dominated by their partners are much more likely to become infected with HIV than women who are not.[22] Violence against women makes it difficult for women to negotiate condom use, safe sex or the timing of sex.[23] In many communities social norms dictate that while women must remain monogamous, men are allowed and even encouraged to engage in sex with multiple partners.[24] Thus, '[m]arriage does not always protect a woman from becoming infected with HIV.

17 A Pino "Violence raises the urgent need for more health services" accessed from https://mg.co.za/article/2019-03-15-00-violence-raises-the-urgent-need-for-more-health-services/ on 19 March 2020.

18. UK Consortium on AIDS and International Development 'Gender and HIV and AIDS', UK Consortium on AIDS Gender Working Group briefing paper (2008) at pp. 1–3.

19. RK Jewkes, K Dunkle, M Nduna and N Shai 'Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa: A cohort study' The Lancet 376(9734) (2010): 41–48. See also UK Consortium on AIDS and International Development (fn. 6 above).

20. Various biological factors increase women's vulnerability to HIV/AIDS. For example, in unprotected heterosexual intercourse women are twice as likely as men to acquire HIV from an infected partner. Physiologically, women are more susceptible to HIV infection than men because the female genital tract has a large, exposed surface area; therefore women are at greater risk of infection with every exposure to the virus. See Human Sciences Research Council; UNAIDS 'Gender and HIV/AIDS: UNAIDS technical update' (1998), http://data.unaids.org/publications/irc-pub05/jc459-gender-tu_en.pdf; UNAIDS 'Report on the global HIV/AIDS epidemic – June 2000' (2000), http://data.unaids.org/pub/Report/2000/2000_gr_en.pdf.

21. UNAIDS 'The gap report 2014: Adolescent girls and young women', http://www.unaids.org/sites/default/files/media_asset/02_Adolescentgirlsandyoungwomen.pdf.

22. KL Dunkle, RK Jewkes, HC Brown et al. 'Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa' The Lancet 363(9419) (2004): 1415–1421.

23 'Women and HIV/AIDS', http://www.avert.org/women-hiv-aids.htm.

24. International Planned Parenthood Federation 'The truth about men, boys and sex: Gender transformative policies and programmes' (2009) at p. 7.

Many new infections occur within marriage or long-term relationships as a result of unfaithful partners.'[25]

In addition, the financial dependence of one partner on the other makes it difficult for the dependant partner with HIV to disclose his or her HIV status and encourage the use of condoms for fear of rejection and loss of financial support. This is especially a problem for dependant partners who know that their partner is having unprotected sex with other people outside the relationship. These problems are exacerbated for people who are in violent relationships.[26] Economically vulnerable people are less likely to terminate a violent or dangerous relationship, less likely to have access to information regarding HIV and AIDS, less likely to use condoms and more likely to resort to high-risk behaviour to secure a source of income.[27] Loss of income often causes people to engage in unsafe sex or informal sex work as a means of survival or to support their families.[28] Women's insecure employment circumstances exacerbate their economic dependence and thus increase their vulnerability to HIV: fewer women than men are employed, and women generally have less job security and are paid less than men.[29]

These patterns of dependence promote relationships in which men are the decision-makers in key areas related to HIV prevention including sexual relations, the use of protection, household spending on health, and access to healthcare.[30] In addition, the denial of women's inheritance and property rights can increase their vulnerability to HIV.[31] Not being able to own property means that women have limited economic stability. This can lead to an increased risk of sexual exploitation and violence in that women may have to endure abusive relationships or resort to informal sex work for economic survival.[32] Furthermore, '[n]ational laws relevant to women's rights with respect to family and property are diverse and encompass a range of statutes, regulations and other forms of subsidiary law, common law, customary law and constitutional provisions. This complicated legal terrain can result in inconsistencies and injustices.'[33]

2.2. Physical and Sexual Violence

Gender-based violence is a direct contributor to risk of HIV infection among South Africans.[34] Sexual assault and domestic violence increase the risk of HIV infection. Violence can elevate the risk of HIV infection directly, through forced sex, and indirectly, by constraining the ability of a survivor to negotiate the circumstances and ways in which sex takes place, including whether condoms are used. In addition, abrasions and tearing occurring when the vagina or anus is dry or when force is used increases the risk of HIV transmission. This is particularly true for younger women and girls, whose genital tracts are still immature. The risks of transmission are higher still if the survivor is subjected to gang rape, given the exposure to multiple assailants.[35] GBV is as

25. 'Women and HIV/AIDS' (fn. 11 above).

26. UNAIDS (fn 9 above) See also Jewkes et al. (fn. 7 above).

27. A Blanc 'The effect of power in sexual relationships on sexual and reproductive health: An examination of the evidence', *Studies in Family Planning* 32(3) (2001): 189–213.

28. Human Sciences Research Council (fn. 3 above) at p. 3. See also M Betron, G Barker, JM Contreras and D Peacock 'Men, masculinities and HIV/AIDS: Strategies for action', http://menengage.org/wp-content/uploads/2014/04/Men-and-Boys_Final_Web.pdf.

29. D Mindry, S Maman, A Chirowodza et al. 'Looking to the future: South African men and women negotiating HIV risk and relationship intimacy' Culture, Health & Sexuality 13(5) (May 2011): 589–602.

30. Pan-American Health Organisation 'The UNGASS, gender and women's vulnerability to HIV/AIDS in Latin America and the Caribbean' (2002), http://www1.paho.org/English/ad/ge/genderandhiv-revised0904.pdf (accessed February 2015) at p. 12.

31. AIDS Accountability International 'Fact sheet on women and HIV/AIDS', http://www.aidsaccountability.org/wp-content/uploads/2009/11/fact-sheet-o-women-and-hivaids.pdf, at p. 1, citing UNDP 'HIV and women's inheritance and property rights' (2009), http://content.undp.org/go/newsroom/updates/hiv-www-news/womens-inheritance-and-property-rights-areessential-to-effective-aids-response.en?src=print.

32. UNAIDS 'Global report: UNAIDS report on the global AIDS epidemic 2010', http://www.unaids.org/globalreport/Global_report.htm.

33. UNAIDS Judging the Epidemic: A Judicial Handbook on HIV, Human Rights and Law (2013), http://www.unaids.org/sites/default/files/media_asset/201305_Judging-epidemic_en_0.pdf, at p. 105.

34. Jewkes et al. (fn. 7 above) at p. 1, referring to S Maman, J Campbell, MD Sweat and AC Gielen 'The intersections of HIV and violence: Directions for future research and interventions' *Soc. Sci. Med.* 50(4) (2000): 459–478, C Garcia-Moreno and C Watts 'Violence against women: Its importance for HIV/AIDS' AIDS 14 (2000): S253–S265 and UNAIDS and WHO 'AIDS epidemic update 2005' (December 2005), http://data.unaids.org/Publications/IRC-pub06/epi_update2005_en.pdf.

35. "Judging the epidemic – A judicial handbook on HIV, human rights and the Law"-UNAIDS/JC 2497 at p. 67

much a cause of HIV as it is a consequence of it. HIV testing services can expose women and girls to the risk of violence due to lack of confidentiality and/or following disclosure of a positive HIV status.[36]

3. Gender-based Violence and South African Law

3.1 The Criminal Law (Sexual Offences and Related Matters) Amendment Act

The Criminal Law (Sexual Offences and Related Matters) Amendment Act[37] (Sexual Offences Act) came into operation at the end of 2007. It sets out the various sexual acts that qualify as sexual offences. In so doing, this Act has made various changes to the earlier law on sexual violence and has also created a number of new offences. Amendments to the Sexual Offences Act have been introduced in the Criminal Law (Sexual Offences and Related Matters) Amendment Act Amendment Bill that seeks to, among other things, extend the ambit of the offence of incest and introduce a new offence of sexual intimidation.[38]

36. POWA Criminal Injustice: Violence Against Women in South Africa https://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/ZAF/INT_CEDAW_NGO_ZAF_48_10364_E.pdf pg 9 accessed 13 October 2020.

37. Act 32 of 2007.

38. https://static.pmg.org.za/B16-2020_Criminal_Law_Sexual_Offences.pdf

OFFENCE	DESCRIPTION OF SEXUAL ACT
Compelled rape	Forcing a person to rape (sexually penetrate) another person[39]
Compelled self-sexual assault	Forcing a person to masturbate herself or himself, to penetrate herself or himself, or to perform any other sexual act with herself or himself[40]
Compelled sexual assault	Forcing a person to sexually assault (sexually violate) another person[41]
Rape	Forced sexual penetration of a male or female's genital organs, anus, mouth or other body part with a penis or an object that can be used for sexual penetration[42]
Sexual assault	Any act which causes direct or indirect contact with the genital organs, anus, mouth, breasts (in the case of a female) or any other part of a person's body which could be used for the purposes of sexual penetration, sexual arousal or stimulation without consent but where sexual penetration does not take place[43]
Sexual exploitation	• Paying for sexual services from a person who is mentally disabled, whether or not the sexual act is actually committed[44] • Offering a mentally disabled person to another person for the commission of a sexual act[45] • As the care-giver of a mentally disabled person, knowingly allowing a sexual act to be committed with that person[46] • Providing (intentionally allows or knowingly permits) immovable or movable property for the commission of a sexual act with a mentally disabled person[47] • Receiving payment for the commission of a sexual act with a mentally disabled person[48] • Supporting or assisting in the commission of a sexual act with a mentally disabled person[49]
Sexual grooming	• Making, giving, owning, possessing or displaying articles or material to a person to help him or her to commit a sexual act with a mentally disabled person[50] • Helping a person communicate with a mentally disabled person for the purposes of that person committing a sexual act with a mentally disabled person[51] • Giving or showing a mentally disabled person articles or material to encourage him or her to commit a sexual act[52] • Committing or describing the commission of a sexual act with a mentally disabled person in order to encourage him or her to commit a sexual act[53]
Unspecified	• Exposing or displaying child pornography to a mentally disabled person[54] • Using a mentally disabled person to produce pornography[55] • Receiving payment for pornography in the making of which a mentally disabled person was used[56] • Forcing or causing a person over 18 years of age to witness a sexual offence or to commit a sexual act without that person's consent[57] • Paying for sexual services from a person over the age of 18 years[58] • Providing sexual acts for reward[59]

39. S 4.
40. S 7.
41. S 6.
42. S 3 read with the definition of 'sexual penetration'.
43. S 5 read with the definition of 'sexual violation'.
44. S 23(1)(a) and (b).
45. S 23(2).
46. S23(3)(a).
47. S23(3)(b).
48. S23(4).
49. S23(5).
50. S 24.
51. S24(1)(b)
52. S24(2)
53. Ibid.
54. S 25.
55. S 26.
56. Ibid.
57. S 8.
58. S 11.
59. Ss 19 and 20 of the Sexual Offences Act 23 of 1957 as amended by the Criminal Law (Sexual Offences and Related Matters) Amendment Act.

3.1.1. Recourse for Someone Who has Been Sexually Assaulted or Raped Under Sexual Offences Act

3.1.1.1. Reporting a Case

Survivors of a sexual offence should report the offence to the police or a healthcare professional, preferably as soon as possible after the offence has been committed. When the offence is reported, the survivor is required to make a statement including details of his or her identity; if possible, details of the identity of the perpetrator; and details of the actual criminal offence committed. This statement will be used by the court if the case goes to court. The survivor must ensure that all the information in the statement is exactly what he or she experienced and is true and correct.

When a survivor reports a sexual offence at a police station, the police member taking the report must do the following:[60]

- Request that the survivor relocate to another area of the station that is out of sight of other persons.
- Reassure the survivor of his or her safety and that the matter will be dealt with professionally and sensitively.
- Determine whether the survivor is in need of medical attention and make arrangements for it should such attention be needed.
- Ask the survivor whether he or she would like to have another person present during the interview and allow such a person to be present.
- Listen to and write down what the survivor says without interrupting him or her or being judgmental.
- Open a docket for the case. If the survivor cannot make a clear and logical statement at the time, open a skeleton docket with a statement from any person accompanying the survivor. The survivor may make a statement at a later stage.

If a sexual offence is reported to the police by telephone, the police must[61]

- Obtain the address of the location from which the survivor is phoning.
- Establish whether the survivor is in any danger.
- Send a police vehicle to the survivor as soon as possible to secure the crime scene and assist the survivor.
- Ask the survivor not to change clothing or wash as doing so would lead to the loss of evidence.
- Ascertain whether the survivor requires an ambulance and, if he or she does require one, dispatch an ambulance to the survivor immediately.

After the report has been made, the police member who took the report must[62]

- Inform the survivor of the case number and investigating officer's details.
- Inform the survivor of the processes that will follow and regularly update him or her on progress with the investigation.
- Inform the survivor of the importance of a medical examination and that he or she may ask the healthcare professional for medical advice.

At the scene of an offence, the first police member on the scene must[63]

- Deal with the survivor professionally.
- Reassure the survivor of his or her safety.
- Obtain a brief explanation of the events that took place.
- Obtain a description of the suspect and relay that information to the police in the area if the suspect could still be close by.
- Listen to the survivor and write down what he or she says.
- Safeguard the crime scene to preserve evidence while also protecting the survivor's privacy and take steps to prevent the spoiling or loss of evidence.

An investigating officer is assigned to each case. The investigating officer is in charge of the investigation and must take the following steps.[64]

- Instruct police members at the scene of the offence.
- Refer the survivor for a medical examination.

60. National Instruction 3/2008: Sexual offences, http://www.saps.gov.za/resource_centre/acts/downloads/sexual_offences/ni/ni0308e.pdf. The Instruction was issued in terms of s 66(1) of the 2007 Sexual Offences Act.

61. Op cit note 61

62. Ibid.

63. Ibid.

64. Ibid.

- Take an initial statement from the survivor and later an in-depth statement. The investigating officer should be sensitive to the survivor's culture, language, religion and gender and must prepare adequately for such statements, allow interested persons to be present if the survivor desires their presence, and advise the survivor of the importance of giving intimate details and not withholding information.
- Keep the survivor informed of any progress with the investigation.
- Before any resultant trial, take an additional statement from the survivor about how the incident has affected his or her life and relationships.
- On the day of the trial, provide the survivor with copies of his or her statements and explain the proceedings to him or her and the fact that media in the court may not publicise details of the case without the court's authorisation to do so.

In case a survivor may have been exposed to HIV, the police member to whom the offence has been reported must inform her or him of the importance of obtaining post-exposure prophylaxis (PEP) to prevent HIV infection. A medical examination of the suspect may also be ordered by a court if it is necessary for the investigation of the case. The investigating officer must ensure that such examination is carried out properly. Access to PEP will be discussed in detail below.

It is important to note that a court may order HIV testing of the alleged offender if the survivor, a person with an interest in the well-being of the survivor or the investigating officer requests it. The investigating officer is responsible for taking all the required steps to make the application and to see it through until the court makes a decision on the application.

After the survivor has reported an offence, the police are responsible for providing her or him with care. If the offence is a result of domestic violence, advise the survivor of the right to apply for a protection order and lay a criminal charge against the offender. The police must provide the survivor with information about medical and counselling services available to him or her. In terms of section 28(3) of the Sexual Offences Act, the survivor must be advised of a range of services including counselling and treatment for sexually transmitted infections, HIV and AIDS.[65]

3.1.1.2. Medical Examination

Survivors of a sexual offence should go for medical examination by a trained forensic healthcare professional as soon as possible after the offence has been committed. The results of the examination are very important because they will be used as evidence during the court proceedings that may follow. It is also preferable that the survivor does not bath or wash after the sexual offence because bathing or washing will remove important physical evidence that could be picked up in the medical examination and used in subsequent court proceedings.

The survivor's right to decide whether to report the sexual offence or to undergo a medical examination must be respected.

- When an adult survivor does not want to report the sexual offence to the police, there is no legal duty on the healthcare professional to report the offence to the police unless the survivor is mentally disabled or an older person in need of care.
- If the survivor is hesitant about reporting the sexual offence, the healthcare professional should address his or her fears and concerns.
- The survivor should be encouraged by the healthcare professional to report the sexual offence within 24 hours of the commission of the offence.
- The healthcare professional should encourage the survivor to allow him or her to collect medical evidence to be kept at the health facility in case the survivor decides to report the sexual offence. The survivor must be informed that the evidence will be kept for a period of 6 weeks and that the healthcare professional will ensure that it is properly secured.

When the survivor is referred by the police or indicates that he or she would like to report the offence to the police for investigation and prosecution,[66]

- The consent form (SAP 308) must be completed before the medical examination can be conducted.
- The healthcare professional must use a sexual-assault evidence collection kit when conducting a medical examination in sexual offence cases.
- The healthcare professional must take a detailed medical history of the survivor.

65. The police member to whom the offence is reported must hand the survivor a copy of form SAPS 580(a), 'Notice of services available to victim', available at http://www.saps.gov.za/resource_centre/acts/downloads/sexual_offences/ni/ni0308_saps580_a.pdf.

66 http://www.justice.gov.za/policy/guide_sexoff/sex-guide02.html.

- The healthcare professional must complete the required J88 form at the time of the examination.[67]
- Forensic or medical evidence must be collected immediately after the medical examination has been completed (mismanagement of the evidence can result in the evidence not being admitted in court).
- The transfer of forensic or medical evidence from one official to another must be confirmed by signature of the officials involved or by a statement by the official receiving the evidence otherwise the evidence may not be admitted in court.

3.1.1.3. Post-exposure Prophylaxis

PEP is an antiretroviral treatment that is used to limit the probability that survivors of sexual violence will contract HIV.

3.1.1.4. Why is PEP Problematic?

PEP is not effective in all instances. It must be taken within 72 hours of exposure to HIV and can have better results if taken within 48 hours of exposure.[68] Rape survivors can obtain PEP from designated public health establishments.[69] Although PEP is also available at private health institutions, access to PEP through such facilities requires the survivor to be covered by medical aid or in a position to pay for such treatment.

3.1.1.5. How to Obtain PEP

The Sexual Offences Act[70] provides that survivors of sexual offences who may have been exposed to HIV infection are entitled to:

- Receive PEP free of charge at a designated public health establishment.
- Free medical advice on PEP before PEP is administered.
- The prescribed list containing the names, addresses and contact details of designated public health establishments providing PEP.

The police member, medical practitioner or nurse to whom a sexual offence is reported must inform the survivor of:

- The importance of obtaining PEP within 72 hours of having been exposed to HIV.[71]
- The fact that he or she can obtain PEP free of charge from a designated public health establishment
- The need to obtain medical advice and assistance in respect of treatment options available if there is a chance that the survivor might have contracted a sexually transmitted infection.

The right to receive PEP is not conditional on the survivor's having a police case number. PEP cannot be withheld because the survivor has not reported the sexual assault to the police nor can a survivor be told to return for PEP after first reporting the offence.

In addition, HIV testing must be provided to the survivor. The survivor must be advised of the availability of counselling prior to the HIV test.[72]

The Department of Health's National Antiretroviral Treatment Guidelines[73] set out the following steps:

- Survivors must begin PEP within 72 hours of having possibly been exposed to HIV.
- A starter pack must be provided to survivors who opt not to undergo an HIV test immediately, who do not want to receive the results of the HIV test immediately or who are unable to consent to an HIV test owing to severe injuries or trauma.

67. The information in the J88 form can be disclosed to the investigating officer and the Department of Justice and Constitutional Development only. The form may be given to the offender's legal representative only if the court orders that the information be disclosed to him or her.
68. The Department of Health's National Antiretroviral Treatment Guidelines (2004), available at http://www0.sun.ac.za/ruralhealth/ukwandahome/rudasaresources2009/DOH/1.%20Antiretroviral.pdf, state that all women and men aged 14 years and older presenting to a health facility within 72 hours of being raped should be offered PEP to prevent HIV transmission. These treatment guidelines were updated in 2013, but the updated guidelines did not amend or replace the 2004 guidelines in respect of the provision PEP. See National consolidated guidelines for the prevention of mother-to-child transmission of HIV (PMTCT) and the management of HIV in children, adolescents and adults', December 2014, http://www.sahivsoc.org/upload/documents/ART%20Guidelines%2015052015.pdf.
69. Ss 28 and 29 of Sexual Offences Act 2007.
70. S 28(1)*(a)*.
71. PEP must be provided to all survivors who have been in contact with the perpetrator's blood, semen or vaginal fluid within that period, even those whose HIV test results are negative.
72. Op cit note 61
73. Op cit note 69

- The remainder of the required treatment should be given to the survivor even if he or she has tested negative.
- Survivors who have financial or logistical problems should be provided with a 28-day treatment supply of PEP and given a future appointment date on which to return to the health institution concerned.
- Survivors who test HIV-positive should be referred for long-term HIV and AIDS care.
- Healthcare professionals in doubt about prescribing AZT and 3TC must seek advice from a physician or referral advice centre.
- Healthcare professionals must explain to survivors the side effects of the drugs.
- Healthcare professionals must advise survivors to return to the health facility concerned if symptoms occur rather than discontinue the use of the drugs.
- Healthcare professionals must improve adherence by encouraging survivors to continue attending counselling sessions, being able to identify the different tablets and knowing when they should be taken and referring survivors to support groups and non-profit organisations providing relevant services and assistance.
- Healthcare professionals must inform survivors that the effectiveness of oral contraception is reduced when PEP is being used and advise them to use non-hormonal forms of contraception.
- Survivors who present themselves for treatment more than 72 hours after having possibly been exposed to HIV must be informed of the fact that PEP is known not to have an impact more than 72 hours after exposure to HIV.
- HIV testing should be offered to survivors who present themselves for treatment more than 72 hours after possible exposure to HIV. Counselling should be provided both before and after testing. Survivors must be informed of the problems with the window period (during which HIV may not be detectable) and testing that could result in false negative results. Survivors who test negative in the first test must be advised to take a second test 6 weeks after the first test.
- Survivors should be given information about local support services that are available to them, and follow-up consultations should be held 1 week, 6 weeks and 3 months after survivors first present themselves for treatment.

3.1.1.6. Other Treatment that Survivors can Access[74]

- Emergency contraception, which should be given to all female survivors who present themselves for treatment within 5 days (120 hours) of the sexual offence. Survivors should be informed that emergency contraception works best when it is taken as soon as possible after the offence has been committed, but survivors cannot be refused it if they present themselves within the 120-hour period.
- Anti-tetanus toxoid, if the survivor was last immunised against tetanus more than 10 years earlier.
- Treatment for sexually transmitted infections.
- Hepatitis immunisation for survivors who have not been completely vaccinated or who have been infected.

3.1.2. Court Proceedings

3.1.2.1. Procedures in Court

(i) Preliminary Court Procedure

- Once the case has been investigated and the investigating officer is satisfied that a proper case has been made out, the docket will be sent to the National Prosecuting Authority (NPA) for it to decide whether the state will prosecute the alleged perpetrator.
- The NPA may decide not to prosecute because, after assessing the allegations and the information, evidence and witness statements on the docket, it is of the view that a sexual offence was not committed. The NPA may also make this decision if it thinks that there is a lack of evidence and that more evidence cannot be obtained. A survivor has the right to review the decision not to prosecute a case via the office of the National Director of Public Prosecutions[75] and through the High Court on the basis of legality.[76]
- If the NPA decides to prosecute the case, the case will be presented to the court for it to decide whether the alleged perpetrator (referred to as the accused in court proceedings) should be convicted of the sexual offence.

74. Ibid

75. Section 179(5)(d) of the Constitution.

76. National Director of Public Prosecutions and Others v Freedom Under Law (67/2014) [2014] ZASCA 58; 2014 (4) SA 298 (SCA); 2014 (2) SACR 107 (SCA); [2014] 4 All SA 147 (SCA).

(ii) Bail Application

- The accused will appear in court a few times before the actual hearing or trial to apply for bail and obtain legal representation and for the prosecution and the accused's legal representative to prepare their cases.
- The accused has the right to apply for bail[77] and the survivor has the right to attend the bail hearing.[78] The prosecutor can argue against the court's granting the bail application and must raise aggravating factors and circumstances in doing so. For example, the prosecutor must raise the fact that the accused is facing other charges of sexual offences and speak to the seriousness of the extent of the sexual offence of which he or she is accused.
- The presiding officer must decide whether the accused should be granted bail. He or she will not grant a bail application if he or she believes that granting it will not be in the interests of justice because:
  - » The accused is likely to pose a danger to the public or will commit a serious criminal offence.[79]
  - » It is likely that the accused will try to evade the trial.[80]
  - » It is likely that the accused will try to interfere with witnesses or destroy evidence.[81]
  - » The release of the accused on bail could undermine the purpose of the criminal justice system,[82] or
  - » It is likely that releasing the accused will disturb public order, peace or security.[83]
- Bail is granted on condition that a certain amount of money is paid.
- The survivor can also ask the prosecutor to request that bail be granted only on certain conditions. The court can attach conditions such as that the accused must not interfere with witnesses (including the survivor), must reside somewhere or with someone specific, etc.[84]
- If the accused fails to comply with the bail conditions, bail can be withdrawn in which case the accused is arrested and taken back to jail to await trial.[85] Failure to comply with bail conditions can result in the accused being fined or imprisoned for a period of up to a year.[86] Should the survivor become aware of the accused contravening the bail conditions, he or she should report it to the investigating officer immediately.

(iii) The Plea

- The presiding officer asks the accused to enter a plea of guilty or not guilty. If the accused admits to committing the crime, he or she will tell the court that he or she is guilty. If the accused has legal representation, the legal representative can hand in a statement to the court which tells the presiding officer that the accused admits to the sexual offence.[87]
- The presiding officer will ask questions to make sure that the guilty plea has been entered voluntarily and that the accused is guilty in law (i.e. admits all the elements of that particular offence).[88] The state has to decide whether the statement handed in under

77. S 35(1)(f) of the Constitution of the Republic of South Africa, 1996 and s 60 Criminal Procedure Act 51 of 1977 (CPA).

78. Bail proceedings are generally held in open court, but s 56 of the Children's Act 38 of 2005 provides that proceedings involving a child (whether as complainant or accused) must be closed and conducted in the presence of only those persons whose attendance is necessary, such as the child accused's parents or legal guardian and legal representative, in order to protect privacy and confidentiality of the child.

79. S 60(4)*(a)* of the CPA.

80. S 60(4)*(b)*.

81. S 60(4)*(c)*.

82. S 60(4)*(d)*.

83. S 60(4)*(e)*.

84. S 60(2B)*(b)*.

85. S 68. See also *S v Kyriacou* 2000 (2) SACR 734 (O).

86. S 67A.

87. S 112.

88. S 112(1)*(b)*. If the presiding officer is of the view that the offence justifies imprisonment or another form of detention without the option of a fine or that a fine of more than R5 000 is justified, or if the prosecutor directs such request to the court, the court has to question the accused about the alleged facts. The prosecutor will direct the request because of the accused's previous convictions or because of other information unknown to the court at that stage. The complexity of the charge may also be a factor in determining whether questioning under s 112(1)(b) is appropriate.

section 112(2) of the CPA is acceptable; if it is not, evidence must be led by the accused. If the state accepts the accused's version, facts on record can be used for the purposes of sentencing.[89]

- If the plea is accepted, proceedings move to the sentencing stage.
- If the accused pleads not guilty or the presiding officer is not convinced that the accused has admitted to committing the offence, the case goes to a full hearing of all the evidence (a trial).[90]

(iv) The Trial

- Because the state brings the case against the accused, the survivor is a witness for the prosecutor and will be required to testify in court as a witness for the state.
- The prosecutor starts by leading evidence that the accused did commit the sexual offence as charged. The survivor will be called as witness and tell the court what happened. The healthcare professional who examined the survivor will also be called to testify.
- During the court proceedings, the accused's legal representative will present the accused's case to the court in an attempt to have the accused acquitted. In doing so, the accused's legal representative will lead evidence and call witnesses to testify in favour of the accused. He or she will question the survivor as a witness. The legal representative's job is to prove that the accused did not commit the sexual offence or that there was a good reason for the accused's commission of the offence – for example, someone forced the accused to commit the offence by putting him or her in fear of his or her life if he or she did not comply.
- The legal representative of the accused can ask the survivor questions about what happened (cross-examination.) If the accused has no legal representative, he or she may cross-examine the survivor.
- The presiding officer hears the evidence for and against the accused. He or she can request that more information be obtained for the prosecution of the case such as further statements from witnesses or other evidence such as clothing items or objects used in the commission of the sexual offence. The proceedings can be postponed to allow this additional information or evidence to be obtained.
- After the court has heard evidence from the prosecution and the accused, the presiding officer will decide whether the accused is guilty of committing the sexual offence. The test that the presiding officer will use is whether it is beyond a reasonable doubt that the accused committed the offence. In other words, it is not reasonably possible that the accused's version that he or she is innocent is true; therefore, the accused must be guilty of the offence.[91]
- It is also possible for the court to convict the offender of a lesser offence if it is not satisfied that sufficient evidence was presented to prove that the accused in fact committed the sexual offence. For example, the accused could be convicted of sexual assault rather than rape or compelled sexual assault rather than sexual assault.

3.1.2.2. Relevant Rules of Evidence

(i) Previous Consistent Statements

If the survivor made statements about the sexual offence before giving evidence in court and makes the same or similar statements during the court proceedings, the statements made before court proceedings began can be taken into account by the court when it is deciding whether to convict the accused. The court cannot hold it against the complainant that he or she made no previous consistent statements or made previous statements that differ from what was said in court (previous inconsistent statements).[92]

Before the Sexual Offences Act came into operation, courts were allowed to hold inconsistent statements against the complainant. This was detrimental to complainants: survivors of sexual offences are often deeply traumatised by their experience and can make inconsistent statements as a result.[93] In these circumstances an inconsistent statement does not necessarily mean that the complainant is not telling the truth.

89. *S v Martin* 1996 (1) SACR 172 (W) at p. 174e–h.

90. S 115 of the CPA.

91. See *S v T* 2005 (2) SACR 318 (E) at para. 37.

92. S 58 of Sexual Offences Act 2007 makes previous consistent statements admissible 'in criminal proceedings involving the alleged commission of a sexual offence' and provides that a court 'may not draw any inference only from the absence of such previous consistent statements'.

93. *S v Hammond* 2004 (2) SACR 303 (SCA).

(ii) Delayed Reporting

The court cannot view the fact that a sexual offence was reported long after it was committed negatively or in favour of the accused. This means that the court cannot conclude that a sexual offence did not happen simply because a long period of time elapsed between the date on which the alleged sexual offence took place and the date on which the complainant reported the offence.[94]

(iii) The Cautionary Rule

In terms of rules of evidence and procedure, the Sexual Offences Act has finally scrapped the use of the cautionary rule in cases concerning sexual offences. This means that courts are no longer permitted to treat the evidence of rape complainants 'with caution' solely because 'of the nature of the offence'.[95] The cautionary rule is a rule of practice aimed at assisting judges in assessing evidence. It requires judicial officers to exercise caution before adopting the evidence of certain witnesses on the grounds that the evidence of such witnesses is inherently potentially unreliable.[96] The rule thus requires presiding officers to regard with caution the evidence of children and accomplices (and previously the evidence of complainants in sexual-offence cases, too).[97]

The Supreme Court of Appeal ruled in 1998[98] that the use of the cautionary rule in cases concerning sexual offences was based on obsolete and irrational assumptions. It held that the rule 'unjustly stereotypes complainants in sexual assault cases (overwhelmingly women) as particularly unreliable. In [the South African] system of law, the burden is on the State to prove the guilt of an accused beyond reasonable doubt – no more and no less. The evidence in a particular case may call for a cautionary approach, but that is a far cry from the application of a general cautionary rule.'[99]

The court endorsed the guidelines formulated by the Court of Appeal of England and Wales in *R v Makanjuola, R v Easton*[100] and held that they ought to be applied in line with South African law, particularly the third guideline which reads

> "In some cases, it may be appropriate for the judge to warn the jury to exercise caution before acting upon the unsupported evidence of a witness. This will not be so simply because the witness is a complainant of a sexual offence nor will it necessarily be so because a witness is alleged to be an accomplice. There will need to be an evidential basis for suggesting that the evidence of the witness may be unreliable. An evidential basis does not include mere suggestions by cross-examining counsel."

The Sexual Offences Act now acknowledges that complainants in cases involving sexual offences should not be treated any differently from complainants in other cases since there is no reason to believe that they are less credible than survivors of other crimes.

3.1.2.3. Character Evidence and Evidence of Sexual History

The court cannot accept evidence of a complainant's sexual history or character unless the accused's legal representative obtains permission from the court to lead such evidence or the prosecution introduces such evidence.[101] This means that the complainant's sexual history cannot be taken into account by the court unless the court allows the accused's legal representative to submit such evidence. Before the court allows the accused's legal representative to lead such evidence, it must be satisfied that the evidence is relevant to the proceedings at hand. In determining whether the evidence is relevant, the court must consider whether it is in the

94. *Bothma v Els and others* 2010 (2) SA 622 (CC). See s 59 of Sexual Offences Act 2007.

95. S 60 of Sexual Offences Act.

96. DT Zeffertt and AP Paizes *Essential Evidence* (Durban: LexisNexis, 2010) at p. 309.

97. Ibid.

98. *S v J* 1998 (2) SA 984 (SCA).

99. Ibid. at p. 1009.

100.[1995] 3 All ER 730 (CA) at p. 733.

101.S 227(2) of the CPA.

interests of justice and society to admit the evidence.[102] The court cannot allow the evidence if, in its opinion, the evidence will support an assumption that, because of the particular nature of the complainant's experience or conduct, it is likely that he or she consented to the sexual act or is less capable of telling the truth.

3.1.2.4. Sentencing

Should the court decide that the accused is guilty of committing a sexual offence, it must punish him or her by imposing a sentence in terms of the Sexual Offences Act. Punishment can include imprisonment, payment of a fine or attendance at a sexual offenders' treatment programme. The sentence that is imposed on the offender depends on the nature and seriousness of the sexual offence and on his or her personal circumstances (such as age, previous convictions and so on) and the interests of the community or society.

Minimum sentences are prescribed for certain sexual offences such as rape. The minimum sentence for rape is 10 years imprisonment.[103] The minimum sentence for a first-time offender convicted of rape is 10 years imprisonment, for a second-time offender 15 years imprisonment and for a third-time offender 20 years imprisonment. Offenders who commit rape in certain circumstances can be sentenced to life imprisonment (which is 25 years imprisonment).[104] This sentence can be imposed on offenders who rape a child under 16 years of age or a mentally disabled person, who commit rape more than once, or who commit rape knowing that they are HIV-positive and could infect their victim with HIV.[105]

Minimum sentences can be deviated from in substantial and compelling circumstances only[106] – there must be a good reason for such a deviation. An offender cannot be given a sentence that is less than the prescribed minimum sentence simply because of the victim's sexual history (e.g. the survivor is a sex worker or has had sexual intercourse with many partners), the survivor was not physically injured during the rape (e.g. the survivor's vagina does not show evidence of forced penetration or the survivor was not beaten while being raped), the accused's cultural or religious beliefs permit his or her actions (e.g. certain religions and cultures say that a wife can never refuse to have sex with her husband), or the survivor had been in an intimate relationship with the accused some time before the rape.

The presiding officer can impose a sentence less severe than the prescribed minimum sentence if he or she is of the view that sufficient 'substantial and compelling' circumstances exist to justify the lesser sentence.[107] He or she must be satisfied that the prescribed minimum sentence does not fit the crime or is too harsh or would be unfair to the offender and the needs of society.[108]

Offenders have the right to appeal against their conviction or the sentence imposed. If an offender succeeds with an appeal, the conviction can be changed to an acquittal or the sentence can be reduced to a lesser sentence.

102. In S v M 2003 (1) SA 341 (SCA) at p. 353 the Supreme Court of Appeal in interpreting s 227(2) of the CPA quoted with approval the following remarks from R v Viola [1982] 3 All ER 73 (CA) at p. 77 in regard to a similarly worded provision of the UK's Sexual Offences (Amendment) Act 1976: '[s2(1)] was aimed primarily at protecting complainants from cross-examination as to credit, from questions which went merely to credit and no more'. The court held that these remarks applied with equal force to s 227(2) of the CPA. The court went on to hold that even in the absence of specific statutory prescriptions it would be proper for a court to consider the following in determining the admissibility of evidence under s 227(2): '(a) the interests of justice, including the right of the accused to make a full answer and defence; (b) society's interest in encouraging the reporting of sexual assault offences; (c) whether there is a reasonable prospect that the evidence will assist in arriving at a just determination in the case; (d) the need to remove from the fact-finding process any discriminatory belief or bias; (e) the risk that the evidence may unduly arouse sentiments of prejudice, sympathy or hostility...; (f) the potential prejudice to the complainant's personal dignity and right of privacy; (g) the right of the complainant and of every individual to personal security and to the full protection and benefit of the law; (h) any other factor that the [presiding officer] considers relevant' (at p. 354, quoting s 276(3) of the Canadian Criminal Code). Courts should grant an application to adduce evidence of or put questions to a complainant about the complainant's previous sexual experience or conduct if they are satisfied that such evidence or questioning '(a) relates to a specific instance of sexual activity relevant to a fact in issue; (b) is likely to rebut evidence previously adduced by the prosecution; (c) is likely to explain the presence of semen or the source of pregnancy or disease or any injury to the complainant where it is relevant to a fact in issue; or (d) is not substantially outweighed by its potential prejudice to the complainant's personal dignity and right to privacy; or (e) is fundamental to the accused's defence' (at p. 355).

103. S 51 of the Criminal Law Amendment Act 105 of 1997.

104. S 51(2)*(b)*.

105. See Chap. 11 on wrongful transmission of HIV.

106. S 51(3) of the Criminal Law Amendment Act 105 of 1997.

107. Ibid.

108. Ibid.

In terms of the CPA survivors of a sexual offence can apply for a compensation order after the offender has been convicted. This means that a survivor can apply to a court for the offender to pay him or her for the costs incurred as a result of the sexual offence. It is important to note that survivors cannot ask for payment for pain and suffering due to the sexual offence or for the psychological or emotional trauma it caused. A survivor can seek monetary compensation from the offender only for financial losses suffered as a result of the sexual offence – for example, hospital and medical expenses, loss of income, the cost of accommodation if the survivor was required to move from his or her home and so on. If a survivor asks for the compensation provided for by the CPA, he or she cannot also sue for damages in terms of civil law.

In the *Levenstein* case, the statutory provision that allowed for the lapse of a right to institute prosecution of sexual offences other than rape or compelled rape after a period of 20 years, from the time the offence was committed, was found to be unconstitutional.[109] There is no longer a time bar on the right to institute criminal prosecution for any sexual offences. The declaration of invalidity is retrospective to 27 April 1994 thereby reinstating the right to prosecute for those who may have lost their right to do so because of the impugned section.

3.2 Domestic Violence Act[110]

The Domestic Violence Act[111] (DVA) sets out the law on domestic violence in South Africa. Its aim is to provide people who are experiencing domestic violence with the best possible protection that the law can provide and to commit the state to stopping domestic violence. The DVA allows you to obtain a protection order against the abuser prohibiting him or her from committing further acts of domestic violence against you. If the abuser commits an act prohibited in terms of the protection order, he or she can be arrested and taken to court for contravening the protection order. Amendments to the DVA have been introduced in Parliament under the Domestic Violence Amendment Bill. The Bill seeks to introduce certain definitions, including the additions of coercive and controlling behaviour, and amendments to the definitions of harm, harassment, intimidation and sexual abuse and harassment. It also markedly makes provision for online applications for protection orders by way of a secure online submission.[112]

3.2.1. When can One Use the DVA for Protection Against Domestic Violence?

You can turn to the DVA for protection if you have been abused by somebody that you are in a 'domestic relationship' with. You must have experienced one or more of the types of abuse set out in the Act.

3.2.2. What is a 'Domestic Relationship'?

You are in a domestic relationship in terms of the DVA[113] if

- You live or lived with the abuser in an intimate relationship or marriage.
- You share or recently shared a residence with your abuser.
- You are married to or in an intimate relationship with your abuser.
- Your abuser is a member of your family (a parent, sibling, child, cousin and so on) or of the family of your current spouse or partner or of a former spouse or partner.
- You and your abuser share responsibility for a child even if you are not the child's natural or adoptive parents or legal guardians.
- Your abuser believes or thinks that he or she is in an intimate relationship with you.

3.2.3. What is Domestic Violence?

Any behaviour or conduct that is abusive or harmful and affects your safety, health or well-being negatively may amount to domestic violence. The DVA lists various types of conduct in its definition of 'domestic violence'.[114]

- **Physical abuse** – When the abuser harms you physically by, for example, beating, slapping, punching, choking, kicking, stabbing or shooting you.

109. Levenstein and Others v Estate of the Late Sid.ney Lewis Frankel and Others (CCT170/17) [2018] ZACC 16; 2018 (8) BCLR 921 (CC); 2018 (2) SACR 283 (CC) (14 June 2018).

110. Act 116 of 1998

111. Ibid.

112. https://static.pmg.org.za/B20-2020_Domestic_Violence6651.pdf

113. S 1 of the DVA s.v. 'domestic relationship'.

114.S 1 s.v. 'domestic violence'.

- **Sexual abuse** – When the abuser harms you sexually by, for example, raping or sexually assaulting you.
- **Emotional abuse** – When the abuser continually harms you emotionally by saying or doing things intentionally to hurt your emotions or feelings. The abuser may do or say such things to get you do what he or she wants you to do – for example, he or she may threaten to take your child away from you if you divorce him or her.
- **Psychological abuse** – When the abuser continually harms you psychologically by saying or doing things intentionally to affect your state of mind negatively. For example, he or she may seek to undermine you or make you feel inadequate in relation to other people.
- **Verbal abuse** – When the abuser continuously harms you verbally by, for example, swearing at or saying disrespectful things to you.
- **Economic abuse** – When the abuser harms you economically or financially by, for example, stealing your money or belongings, refusing to buy food for the children or to pay their school fees, or using money to manipulate you.
- **Intimidation** – When the abuser threatens to hurt or harm you, your children, friends or family to get you to do what she wants you to do or bullies, scares or pressurises you to do or not do something. Psychological, emotional and verbal abuse can amount to intimidation.
- **Harassment** – When the abuser continually watches you, sends you unwanted letters, faxes or text messages or calls you repeatedly or when the abuser enters your home, which you do not share with him or her, without your consent.
- **Stalking** – When the abuser continually follows you around or watches you and you do not want him or her to do so.
- **Damage to property** – When the abuser intentionally damages or destroys your property. For example, he or she may break, destroy or spoil your personal belongings, furniture or home (in the case of your home, by damaging the doors or breaking the windows, for example).

3.2.4. Who Can Apply for a Protection Order?[115]

Anyone being abused by somebody with whom he or she is in a domestic relationship (as defined above) may apply for a protection order. Any person concerned[116] about an abused person's well-being, including a social worker, teacher, health worker or member of the police service, may apply for a protection order on behalf of that person. If somebody applies for a protection order on behalf of another, the latter's written consent to the application is required unless he or she is a minor, mentally challenged or unconscious or the court is otherwise satisfied that he or she cannot give the required consent.

3.2.5. Where does One Apply for a Protection Order?

You can apply for a protection order at the magistrates' court nearest your home or place of work, nearest the abuser's home or place of work or nearest where the abuse took place. Should the protection order be issued it will be enforceable anywhere in South Africa.

3.2.6. When can One Apply for a Protection Order?

You can apply for a protection order at the court during ordinary court hours. But, if the court is satisfied that you may suffer 'undue hardship' if your application is not dealt with immediately, you may apply for a protection order outside ordinary court hours, even on weekends and public holidays.[117]

3.2.7. How does One Apply for a Protection Order?

The domestic-violence clerk at the magistrates' court will require you to complete an application form and an affidavit setting out all the information relevant to the abuse, such as your full details, the abuser's full details and a description of the abuse that took place. You should also take along any relevant documentation such as your identity document, the J88 form completed by your doctor, photographs showing the results or effects of the abuse, affidavits from people who witnessed the abuse and so on.

It is important that you have the address of the abuser's home or place of work so that documents can be served on the abuser. Once the application form and affidavit have been completed the domestic-violence clerk will

115. S 4.

116. That is, with a 'material interest' in an abused person's well-being – e.g. a parent or close friend.

117. S 4(5).

give them to the magistrate who will then decide whether an interim protection order should be issued.

You can lay criminal charges against the abuser even if you have applied for or obtained a protection order against him or her.

3.2.8. When will the Magistrate Issue an Interim Protection Order?

If the magistrate is of the view, from the documents that you have furnished her or him with, that an act of domestic violence is being committed or has been committed against you and that you will suffer undue hardship as a result of that violence if an interim protection order is not issued immediately, he or she will issue an interim protection order.[118] The magistrate may request additional information in the form of affidavits or may ask to speak to you or witnesses in order to decide whether to issue the interim protection order.

3.2.9. What Happens when the Interim Protection Order is Issued?

If the magistrate decides to issue the interim protection order, the following documents must be served on the abuser by the sheriff of the court or a member of the police service:

- A copy of your application documents.
- Copies or recordings of any documents or information that the magistrate took into account in reaching her or his decision to issue the interim protection order.
- A copy of the interim protection order.
- A notice calling on the abuser to appear in court on a specific date to tell the court why the interim protection order should not be made final.[119]

You are required to take the documents to the sheriff or the police yourself. You will also be required to pay the sheriff a service fee. The police, on the other hand, serve the documents free of charge.

The abuser cannot be called to appear in court in terms of the notice less than 10 days after the documents have been served on him or her. This notice period gives the abuser time to prepare for the hearing. The interim protection order can be used legally against the abuser only after it has been served on him or her.

If the magistrate decides not to issue the interim protection order, the court must serve copies of the application, any affidavits and a notice calling on the abuser to appear in court on a specific date to explain to the court why the order should not be issued.[120]

3.2.10. What Happens if the Abuser Does not Attend the Court Hearing?

The court will issue the final protection order in the absence of the abuser if the court believes that the documents were served on the abuser properly and that the abuser has committed or is committing an act of domestic violence.[121]

3.2.11. What Happens at the Court Hearing?

At the court hearing the magistrate will consider all the documents relevant to the application and may ask you and the abuser questions to help her or him decide whether to make the interim protection order a final order. The court may also allow the abuser to question you. Both abuser and victim are entitled to be legally represented during proceedings. If the abuser does not have a legal representative you can ask the court to direct that he or she not be allowed to question you directly. If the court grants your request the abuser will have to direct his or her questions to the magistrate who will then ask you the questions.[122]

3.2.12. What Can the Court Prohibit the Abuser from Doing in the Protection Order?

The court can prohibit the abuser from:

- Committing any act of domestic violence.
- Arranging others to commit an act of domestic violence.
- Entering the home or a specified part of the home he or she shares with you.
- Entering your home, if you and he or she do not share a home.

118. S 5(2).

119. S 5(3) and (4).

120. S 5(4).

121. S 6(1).

122. S 6(3).

- Entering your workplace.
- Committing any other act of domestic violence.[123]

3.2.13. What Else can the Court Order in the Protection Order?[124]

The court can make any other order that it believes is reasonably necessary for the protection of your health, safety and well-being including an order:

- Preventing you from entering or continuing to share a residence with the abuser or from entering part of the shared residence.
- For the removal of any firearm or dangerous weapon in the possession of the abuser.
- For a peace officer to accompany you when you collect personal property or make arrangements to collect your personal property from a place where you may be in danger from the abuser.
- Compelling the abuser to pay the rental or bond payments in respect of your home, having regard to your respective financial situations.
- Compelling the abuser to pay you emergency monetary relief for costs or expenses that you have incurred as a result of the domestic violence such as medical, hospital and dental costs, loss of income, and the cost of temporary accommodation (again, after considering both your respective financial situations).
- Prohibiting the abuser from having contact with any child born of the relationship or living with you or setting out conditions the abuser must meet in order to have contact with the child if such contact is not or will not be in the best interests of the child.

3.2.14. What if the Abuser Contravenes the Conditions in the Protection Order?

Should the abuser commit an act of domestic violence that he or she is prohibited from committing in terms of the protection order, you can approach the police to arrest him or her in terms of the warrant of arrest attached to the protection order. You will be required to make an affidavit describing how he or she contravened the conditions in the protection order. In other words, you must explain how you were abused and that this abuse is prohibited in the protection order. The police member attending to the report must either arrest the abuser or send him or her a notice to appear in court.[125]

Committing an act of domestic violence that is prohibited in the protection order is a criminal offence.[126] An abuser arrested for contravening the conditions in the protection order must appear before a magistrate in criminal court. If the court finds that the abuser committed the prohibited act, it can order that he or she be imprisoned for no longer than 5 years, fine him or her, or order that he or she be both fined and imprisoned.[127]

3.2.15. What are the Duties of the Police?

In addition to the duties of the police specified in the DVA, the National Commissioner of Police has issued a National Instruction on Domestic Violence.[128] The purpose of the National Instruction is to guide members of the police service in executing their duties in terms of the DVA.

The police's duties in terms of the DVA and National Instruction are:

- To assist you in any way necessary at the scene of the abuse (for example, by helping you find alternative temporary accommodation or obtain medical treatment or counselling services).
- To inform you as far as is reasonably possible of your rights in terms of the DVA in a language that you understand and provide you with the relevant documentation to assist you in using the DVA.
- To inform you of your right to lay a criminal charge against the abuser in addition to applying for a protection order against him or her (for example, if you were sexually abused you can lay a charge of rape or sexual assault, as the case may be, or if you were physically abused you can lay a charge of assault or assault with intent to do grievous bodily harm).

123. S 7(1).

124. Ibid.

125. S 8.

126. S 17.

127. Ibid.

128.National Instruction 7/1999 in *Government Gazette* 20778 of 30 December 1999.

- To confiscate any firearm or dangerous weapon in the abuser's possession that poses a threat to you.
- To arrest the abuser at the scene of the abuse if the police member concerned is of the opinion that an act of domestic violence was committed.
- To arrest the abuser when you report a violation of the conditions in the protection order, even in the absence of a warrant of arrest.[129]
- To serve on the abuser the interim protection order, final protection order, or notice calling on him or her to attend court.
- To record the domestic-violence incident in the domestic-violence register.

3.2.16. What if the Police Fail to Execute their Duties?

Should a member of the police service fail to perform his or her duty, you can lodge a complaint with the station commissioner at the police station where the police member works. The station commissioner must take disciplinary steps against the police service member concerned. You can also lodge a complaint with the Independent Police Investigative Directorate at the same time. In addition, you can lodge a complaint with the Directorate if you are not satisfied with the manner in which the station commissioner is handling your complaint. The Directorate has the power to investigate misconduct claims against all police service members.

3.2.17. How is a Protection Order Terminated?

A protection order is terminated only when you withdraw or cancel it or when the court sets it aside. It can be used and remains in force until it is withdrawn, cancelled or set aside.[130] In other words, a protection order can be used on several occasions and even indefinitely without being set aside.

3.2.18. How is a Warrant of Arrest Terminated?[131]

A warrant of arrest is terminated if it is lost or destroyed or when it is used to have the abuser arrested for committing an act of domestic violence that he or she is prohibited from committing in terms of the protection order. Should the abuser commit another act of domestic violence against you after you have used the warrant of arrest, you will need to obtain another warrant from the magistrates' court. You will be required to make an affidavit stating that the previous warrant has been terminated and that you need another warrant to protect yourself from the abuser.

4. Remedies Against the Accused in Sexual Violence Cases

4.1. Can the Accused be Forced to Take an HIV Test?

In terms of the Sexual Offences Act a survivor of a sexual offence can apply to court for an order that the person who allegedly committed the sexual offence take an HIV test and that the results of the test be given to the victim.[132] This application can also be brought by any person who has an interest in the survivor's well-being or by the officer investigating the case.[133] The application must be brought within 90 days of the date on which the sexual offence was committed.[134]

Such an application can be made only if the survivor was exposed to the bodily fluids of the offender. Should the application succeed, the investigating officer must take the offender for an HIV test. The HIV test results must then be given to the applicant in writing. The test results are private and confidential and must not be disclosed to others.

129. If the police member concerned is of the opinion that you will be or are likely to be abused by the abuser should the abuser not be arrested, he or she must arrest the abuser. If the police member is of the view that you will not be or are not likely to be abused, he or she must issue the abuser with a notice informing the abuser of the allegations and calling on him or her to appear in court on a specified date.

130. S 10 of DVA.

131. S 8.

132. S 30(1).

133. Ss 30(1) and 32.

134. S 30(2).

4.1.1. Problems with Compulsory HIV Testing

The provision for HIV testing was introduced with a view to protecting the interests of survivors of sexual violence if there is a potential problem. If the person who committed a sexual offence is tested for HIV during the window period the test will not indicate that he or she has contracted HIV. This means that the test results can indicate that he or she is HIV-negative even though he or she is HIV-positive. In these circumstances a negative result could be false and lead the survivor to believe that he or she does not have HIV.

4.1.2. Procedure for Compulsory HIV Testing

- The healthcare provider treating the survivor must ensure that the latter is aware that, if he or she wishes to apply for compulsory HIV test of the alleged offender, the application must be made within 90 days of the sexual offence.
- The results of the HIV test must be made available to the investigating officer only. That officer will give them to the alleged offender.
- The results of the HIV test of the alleged offender must be dealt with confidentially. The relevant healthcare provider must communicate them to the alleged offender in writing in a sealed envelope.
- One set of test results must be kept at the healthcare establishment that conducted the test and must be made available to the prosecutor for the purposes of prosecuting the offender for the sexual offence.
- The survivor must be counselled before being given the test results.

The healthcare professional must ensure that the test is conducted confidentially and that the results of the test are kept confidential. Test results must be kept in a locked cupboard or cabinet to which access is restricted to the head of the healthcare facility concerned.

4.2. Civil Action Against an Offender

Besides using the criminal justice system, survivors of sexual offences can also sue offenders for damages in civil court. Survivors can sue offenders for compensation for monetary losses (including hospital and medical expenses, loss of income or earnings, future hospital and medical expenses, etc.) and for pain and suffering caused by the sexual offence. Before a survivor institutes a damages claim against the offender, however, it is important that he or she determine whether the offender actually has money with which to compensate the survivor; if the offender does not have money there is no use in instituting a damages claim.

Survivors can also institute a claim against the perpetrator in the Equality Court for the violation of their rights or sue the perpetrator in an ordinary court for money for the harm suffered as a result of the sexual offence. To succeed with a claim in the Equality Court the survivor must be able to prove that the sexual offence committed against him or her amounted to unfair discrimination on the basis of his or her gender and sex. If unfair discrimination of this sort cannot be proved by the plaintiff, the case will not succeed. Accordingly, this sort of claim is not suitable in all cases. It is recommended that before one institute a claim legal advice be sought or legal services engaged to assess whether the claim will succeed. In order to win a case one must be able to prove the allegations that one has made and comply with the requirements for the type of claim that one wants to institute against the offender.

Lawyers' fees are very expensive and often survivors cannot afford to pay them. Free legal advice and assistance are provided by many public-interest and non-profit organisations. It is also important to note that if you lose your case you may be required to pay the other party's legal fees as well as your own. If you cannot afford to pay these costs, your assets – your house or car, for example – could be sold to pay them. It is therefore very important that you carefully consult with your lawyer about your chances of success in any civil matter.

5. Sexual Violence and State Liability

Sometimes the state fails to do what it is required to do in terms of the law. For example, the police might refuse to allow a survivor to lay a charge, or the prosecutor might fail to oppose the perpetrator's bail application and, whilst out on bail, the perpetrator rapes the survivor again, or a state employee might sexually assault the survivor instead of helping him or her. In these situations the state can be sued for damages. Suing the state for damages does not mean that the survivor cannot also lay a criminal charge against the individual who committed the sexual offence. It is also recommended that legal advice or assistance be sought in instituting such claims.

The following case summaries are important because they deal with the constitutional rights against violence and help explain the duties the state owes survivors in terms of these rights.

In *Carmichele v Minister of Safety and Security and another (Centre for Applied Legal Studies intervening)*[135] the applicant sued the state in the person of the Minister of Safety and Security for damages for the harm that she suffered as a result of being brutally attacked by a man who was out on bail, awaiting trial for the alleged attempted rape of another woman. Despite his history of sexual violence, the police and prosecutor had recommended his release on bail. In the High Court the applicant alleged that she was attacked because the police and prosecutor had failed to fulfil the duty of care that they owed her as state officials in terms of her constitutional rights to life, equality, dignity, freedom and security of the person, and privacy. The High Court dismissed her case on the basis that she had not proved that the police or prosecutor owed her these duties in terms of the law. The applicant appealed to the Supreme Court of Appeal which also held that the police and prosecution did not owe her a duty of care and could not be held responsible for the harm that she had suffered. The applicant then appealed to the Constitutional Court. The Constitutional Court held that the other courts that had heard the matter are under a general duty to develop South African law in accordance with the principles of the Constitution and the state's constitutional duty to protect the rights of women. The court further held that the state is obliged by the Constitution and international law to prevent gender-based violence and to protect the dignity, freedom and security of women. Finally, the court held that prosecutors, who are under a general duty to place before the court information relevant to the refusal or granting of bail, may reasonably be held liable for negligently failing to fulfil that duty. The Constitutional Court referred the case back to the High Court for trial. The High Court subsequently held that the state in fact owed the applicant a constitutional duty of care to protect her against violent crime in terms of her constitutional rights.

In *Van Eeden v Minister of Safety and Security (Women's Legal Centre Trust as amicus curiae)*[136] the applicant sued the state for damages after she was sexually assaulted and robbed by a dangerous criminal and serial rapist who had escaped from police custody two months and a half prior to the attack. The applicant initially instituted proceedings in the High Court, alleging that the state owed her a duty to take reasonable steps to ensure that the attacker did not escape and harm her and that the state had negligently failed to fulfil this duty. The High Court, however, held that the state did not owe her a duty to protect her against harm. The applicant then appealed to the Supreme Court of Appeal. That court held that in terms of the applicant's constitutional right to freedom and security and the state's constitutional duty to protect the applicant by preventing violations of this right the police owed the applicant a duty to prevent the attacker from escaping from police custody and harming her. The court further held that the state has a constitutional duty to protect and fulfil all rights in the Bill of Rights and to fulfil its international law duty to protect women from violent crime as a form of gender-based violence. The court also held that the police had a duty to protect the applicant on the basis that the South African Police Service Act,[137] which governs the police, requires the police to maintain law and order and to protect women from violent crime. The court identified the police as one of the main state departments through which the constitutional duty to protect citizens should be executed.

In *K v Minister of Safety and Security*[138] the applicant was brutally raped by three uniformed policemen who gave her a lift. The Supreme Court of Appeal held that the state was not liable for the actions of the policemen because in committing the offence they had not acted in the course and scope of their employment with the state. The applicant then appealed to the Constitutional Court. The Constitutional Court held that the state was indeed liable for the actions of the policemen on the basis that the law has to be developed in terms of the principles of the Constitution. It also held that the policemen had failed to fulfil their duty to protect members of the public in terms of both the Constitution and the South African Police Service Act and that such failure was closely connected to the policemen's employment as in the police service.

The Convention on the Elimination of all Forms of Discrimination against Women affirms that States must take all appropriate measures to eliminate discrimination against women by any person or organisation. States may also be responsible for private acts if they fail to act with due diligence to prevent violations of rights or to investigate and punish acts of violence, and for providing compensation.[139]

135. 2001 (4) SA 938 (CC).

136. 2003 (1) SA 389 (SCA).

137. Act 68 of 1995.

138. 2005 (6) SA 419 (CC).

139 Hellum A and Singding H (eds) Women's Human R ights: CEDAW in International, Regional and National Law (CUP, 2013)

CHAPTER 6

EMPLOYMENT LAW IN THE CONTEXT OF HIV AND TB

1. Introduction

People living with HIV (PLHIV) and Person with Tuberculosis (PWTB) are often faced with stigma and discrimination in all areas of their lives. These discriminations often occur in the workplace, at either the recruitment stage, during employment and often times on termination of employment.

An employee's right not to be discriminated on the basis of their HIV or TB status is embodied in the Constitutional right to dignity and equality. This means that an employer cannot use an employee's status to deny them equal treatment in so far as access to employment benefits, incentives and promotions are concerned. A non-discriminatory work environment is one in which an employee does not receive different occupational treatment because of their HIV and TB status.

South Africa has two primary statutes that protect employees from workplace discrimination.

- The right to equality of treatment in the workplace is given effect to by the Employment Equity Act 55 of 1998 (EEA) that prohibits unfair discrimination.
- The right not to be unfairly dismissed is protected by the Labour Relations Act 66 of 1995 (LRA).

Collectively these statutes promote equal opportunity and fair treatment in the workplace and give effect in the workplace to the constitutional guarantees of dignity and equality.

2. What is HIV and TB Discrimination in the Workplace?

2.1. The Relationship between Employment Law and the Constitution

The South African Constitution is founded on, amongst other things, 'Human dignity, the achievement of equality and the advancement of human rights and freedoms' and on 'Non-racialism and non-sexism'.[1] In terms section 9(2) equality includes the 'full and equal enjoyment of all rights and freedoms. '[L]egislative and other measures designed to protect or advance persons, or categories of persons, disadvantaged by discrimination may be taken to promote the achievement of equality.

The LRA deems dismissal based on any one of the listed grounds in section 9 of the Constitution and the reasons listed under section 187 of the LRA to be unfair discrimination and therefore automatically unfair. The EEA on the other hand was promulgated to address workplace inequality and is the primary legislation prohibiting unfair discriminatory workplace practices.

The Constitution is the basis for the promulgation of the LRA and the EEA. The constitutional value of dignity and the right to equality underpin and give meaning to the provisions of the LRA and EEA directed at the eradication of discrimination.[2]

In the workplace dignity entails two complementary elements, namely:[3]

- how employees are treated by employers; and
- how they employees treat one another in the workplace.

In *Hoffman v South African Airways*[4] the court discussed the right to dignity and equality of HIV-positive employees. In this case, Hoffman (the 'appellant') applied for employment as a cabin attendant with South African Airways (SAA) in September 1996. He successfully completed a four-stage selection process. The appellant was found to be a suitable candidate for employment subject to a pre-employment medical examination that included a blood test for HIV. Whilst the medical examination found the appellant to be clinically fit and therefore suitable for employment, he was deemed 'unsuitable' due to the HIV positive test. He challenged the constitutionality of the refusal to employ him on the basis that it was unfair and violated his constitutional right to equality, human dignity, and fair labour practices. The Witwatersrand High Court dismissed Hoffman's application and he was granted leave to appeal directly to the Constitutional Court.

1. S 1*(a)* and *(b)* of the Constitution.
2. A Vukeya Motsepe ' HIV and the Law in South Africa: A Practitioners Guide' (Lexis Nexis 2016) at 63.
3. Ibid.
4. 2001 (1)SA 1 (CC)

The Constitutional Court set out that those living with HIV, including the appellant, were a vulnerable minority treated with intense prejudice by society and subjected to disadvantage, stigmatisation and marginalisation. As such any discrimination could be interpreted as a fresh instance of stigmatisation and assault on their dignity. The impact especially in the field of employment can be devastating since it denies them a right to a living, condemning them to 'economic death'.

The Constitutional Court further held that a person's dignity is impaired when a person is unfairly discriminated against. It concluded that the refusal to employ the appellant violated his right to equality as guaranteed by section 9 of the Constitution. The Constitutional Court ordered that the appellant, having been denied employment solely because of his HIV status, should be entitled to the fullest redress available, namely reinstatement from the date of the court order.

2.2. International Law and Protection Against HIV and TB Discrimination in the Workplace

2.2.1. Introduction

The International Labour Organisation (ILO) was founded under the Treaty of Versailles in 1919. Its principal purpose is to provide for international regulation of labour standards with the view of ensuing peace, social justice and the elimination of "unfair competition" based on exploitative and inhumane conditions of labour.[5] As a member state of the ILO, South Africa is under various international law obligations. These obligations are a starting point to a working understanding of the specific protection afforded to employees infected and affected by HIV. By 30 April 2000, South Africa had ratified the ILO's core conventions three of which are relevant for the purposes of this section:

- 1958 Discrimination (Employment and Occupation) Convention[6] (Discrimination Convention);
- 2001 Code of Practice on HIV/AIDS and the World of Work[7] (ILO Code); and
- 2010 Recommendation concerning HIV and AIDS and the World of Work[8] (Recommendation 200).

Collectively the Convention, Code and Recommendation 200 set the tone for the prohibition of workplace discrimination and for the promotion of equality. In addition, the Code and Recommendation detail what the prevention of discrimination on the basis of HIV specifically entails.

The ILO Code defines the rights and responsibilities of the constituents of the ILO; it serves as a guide to their complementary or joint actions.[9] The Code was promulgated with the realisation that HIV is a threat to the world of work in that it results in declining productivity, increased labour costs and loss of skills and experience. The hope is that the Code 'will be instrumental in helping prevent the spread of the epidemic, mitigate its impact on workers and their families and provide social protection to help cope with the disease'.[10]

The Code addresses the following areas of concern:

(a) prevention of HIV/AIDS;

(b) management and mitigation of the impact of HIV/AIDS in the world of work;

(c) care and support of workers infected and affected by HIV/AIDS; and

(d) elimination of stigma and discrimination on the basis of real or perceived HIV status.[11]

Section 4 of the code prohibits discrimination against HIV-positive employees and sets out the Code's key principles on the prohibition of discrimination, with the starting point being that HIV 'should be treated like any other illness/condition in the workplace'. When company policies and programmes regarding HIV are designed with this principle in mind, there will be little room for arbitrary differentiation based on an employees' HIV status. Over time such policies and programmes will

5. Labour Relations Law : A comprehensive Guide 4th edition D Du toit and others
6. Available at http://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100_ILO_CODE:C111.
7. Available at http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/publication/wcms_113783.pdf.
8. Available at http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/normativeinstrument/wcms_142706.pdf.
9. http://www.ilo.org/aids/Constituents/lang--en/index.htm.
10. See the preface to the Code.
11. S 1 of the Code.

result in the eradication of discrimination against HIV-positive employees.

2.2.2. Application of International Labour Law in South Africa

In accordance with these obligations, South Africa has adopted legislation and policies giving effect to employees' overall right to fair labour practices, including specific protection for HIV-positive employees. The specific legislative policy directed at eliminating HIV discrimination is the EEA Code of Good Practice: **Key Aspects of HIV/AIDS and Employment (GNR1298 of 01/12/00)**, which must be understood and implemented together with the Technical Assistance Guidelines on HIV and AIDS adopted to complement the Code of Good Practice.

In *Allpass v MooiKloof Estates (Pty) Ltd t/a Mooikloof Equestrain Centre*[12], the applicant sought relief for dismissal from employment on the grounds of his HIV status. In this case, the applicant was employed by the respondent as a manager of a stable and a horse riding instructor at the Mooikloof Equestrian Centre (the "Centre"), owned by the respondent. In the pre-employment interviews, the applicant was asked about his health, and he stated that he was in good health. The applicant had been living with HIV for 18 years and was on a treatment regime. Therefore, according to his medical expert, he was in excellent health. A week later, he and other colleagues were asked to complete a Personal Particulars Form ("PPF"), and amongst others, it required information about allergies and medication taken for these allergies as well as medication for chronic conditions. The applicant listed chronic conditions including HIV, and indicated the anti-retroviral medication he was taking. A few days after he had submitted the PPF, a confrontation ensued between the applicant and his employer, which resulted in his dismissal.

The court pointed out that although the Discrimination Convention does not list HIV as a prohibited ground of discrimination, this omission led to the ILO passing Recommendation 200.[13] The court held that this Recommendation recognises 'the impact of discrimination based on real or perceived HIV status and its increasing prevalence.

In a manner similar to HIV, TB has been identified as a workplace issue because it 'affects the health of workers and the productivity of enterprises.'[14] It has been recognised that HIV has fuelled the increase in TB as people with weakened immune systems due to HIV are particularly vulnerable to TB. This close link between TB and HIV makes it crucial for employers to establish HIV and TB workplace policies that not only promote the health of their employees but also promote a work environment that is non-discriminatory.

This means that '[no] one should experience discrimination on the basis of their TB status, whether in terms of continuing employment relationships or access to health insurance, occupational safety, and healthcare schemes. Employees with TB should be entitled to work for as long as they are medically fit and appropriate work is available.'[15]

HIV and TB discrimination in the workplace is described as:

- Retrenchment due to repeated sick leave.
- Unfair dismissal on the basis of frequent absenteeism.
- Lack of access to advanced training and promotion opportunities.
- Avoidance by management and co-workers for fear of contamination.
- Inappropriate and unfair rumour about employees who have or may have TB and HIV.[16]

3. Employment Legislation

3.1. Labour Relations Act

The LRA was passed by Parliament to regulate relations between employers and employers. Amongst other things, the Act mandates equal rights to all employees and employers regardless of the sectors in which they operate. Its object is to realise the fundamental rights of

12. (2011) 5 BLLR 462 (LC)

13. Recommendation 200 is the first human rights instrument to focus on HIV and AIDS in the world of work.

14. International Labour Organisation: Tuberculosis Guidelines for Workplace Control Activities https://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/publication/wcms_116660.pdf

15. Ibid at 4

16. https://www.justice.gov.za/vg/hiv/docs/tb/FactSheet_discrimination.pdf

workers, which it does through entrenching, amongst other things, the right of all workers to fair labour practices and protection against unfair dismissals.

The LRA applies to all employees, but, unlike section 9 of the EEA, section 5(2) of the LRA protects applicants for employment in cases of victimisation only – 'i.e. a refusal by an employer to engage an applicant on a number of impermissible grounds.'[17] These grounds do not explicitly extend to HIV. Discriminatory practices based on HIV are actionable under the EEA which in terms of its section 9 applies to applicants for employment.

The LRA applies to all employees except those excluded by section 2, namely persons employed by the National Defence Force and the State Security Agency.

The provisions prohibiting unfair dismissals and unfair labour practices are contained in Chapter VIII of the Act. Chapter VIII begins with section 185 which states that '[e]very employee has the right not to be *(a)* unfairly dismissed; and *(b)* subjected to unfair labour practice'. The LRA then goes on to define what an unfair labour practice and unfair dismissal is and distinguishes between unfair dismissals and automatically unfair dismissals.

Section 186(2) reads as follows:

(2) 'Unfair labour practice' means any unfair act or omission that arises between an employer and an employee involving –

(a) unfair conduct by the employer relating to the promotion, demotion, probation (excluding disputes about dismissals for a reason relating to probation) or training of an employee or relating to the provision of benefits to an employee;

(b) the unfair suspension of an employee or any other unfair disciplinary action short of dismissal in respect of an employee;

(c) a failure or refusal by an employer to reinstate or re-employ a former employee in terms of any agreement; and

(d) an occupational detriment, other than dismissal, in contravention of the Protected Disclosures Act, 2000 (Act No. 26 of 2000), on account of the employee['s] having made a protected disclosure defined in that Act.

Automatically unfair dismissals are governed by section 187 and other unfair dismissals by section 188. The relevant parts of these sections provide as follows:

187. Automatically unfair dismissals

(1) A *dismissal* is automatically unfair ... if the reason for the dismissal is –

...

(f) That the employer unfairly discriminated against an employee, directly or indirectly, on any arbitrary ground, Including, but not limited to race, gender, sex, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, political opinion, culture, language, marital status or family responsibility.

188. Other unfair dismissals

(1) A dismissal that is not automatically unfair ... is unfair if the employer fails to prove –

(a) that the reason for dismissal is a fair reason –

(i) related to the employee's conduct or capacity; or

(ii) based on the employer's operational requirements; and

(b) that the dismissal was affected in accordance with a fair procedure.

Section 187(1) (f) of the LRA further provides that:

> *'A dismissal is automatically unfair if the employer, in dismissing the employee, acts contrary to section 5 or, if the reason for the dismissal is that the employer unfairly discriminated against an employee, directly or indirectly, on any arbitrary ground, including, but not limited to race, gender, sex, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, political opinion, culture, language, marital status or family responsibility.'*

This for example means that an employer cannot dismiss or take an employer off certain work because of their HIV or TB status.

In *Bootes v Eagel ink Systems (Pty) Limited*[18] the employee was twice hospitalised with full-blown AIDS and the condition was known to the respondent employer. The employee recovered but was later

17. J Grogan *Dismissal, Discrimination and Unfair Labour Practices* 2nd edn (Cape Town: Juta, 2007) at p. 23.

18. (D781/05) [2007] ZALC 185 (31 August 2007)

dismissed, allegedly for misconduct. The court found that misconduct could not have been the reason for the dismissal, but that the employee was dismissed because he was HIV-positive The court held that any conduct set out in section 186(2) in respect of which the basis of discrimination is HIV constitutes an unfair labour practice for the purposes of the LRA. Furthermore, any dismissal based on an employee's actual or perceived HIV status is automatically unfair for the purposes of section 187, and like a dispute concerning an unfair labour practice is also actionable under the LRA.

3.2. Employment Equity Act

Section 9 (4) of the Constitution states that national legislation must be enacted to prevent or prohibit unfair discrimination'. In the context of preventing workplace discrimination, this national legislation takes the form of the EEA which was promulgated to give effect to the right to equality in the workplace.

EEA advances the rights of groups disadvantaged by past discriminatory practices and is the piece of legislation that employees who are victims of unfair discrimination in the workplace, including discrimination based on HIV, must rely upon. Thus, the prohibition of unfair discrimination in the workplace is regulated by the EEA and read with the Constitution.

The EEA was promulgated to promote equality and prevent unfair discrimination in the workplace and to give effect to South Africa's obligations as a member of the ILO. It is the most significant piece of legislation creating inclusive protection of HIV-positive employees. Section 6(1) of the EEA lists HIV as a prohibited ground of discrimination setting in place a more rigid anti-discrimination measure than section 9 of the Constitution.

Chapter 2, section 6 of the Act provides as follows:

> *'(1) No person may unfairly discriminate, directly or indirectly, against an employee, in any employment policy or practice, on one or more grounds, including race, gender, sex, pregnancy, marital status, family responsibility, ethnic or social origin, colour, sexual orientation, age, disability, religion, HIV status, conscience, belief, political opinion, culture, language, birth or on any other arbitrary ground;'.*

The EEA prohibits any unfair discrimination against an employee or job applicant on the basis of any of the abovementioned grounds.

3.2.1. Medical Testing in the Workplace

Section 7 of the EEA deals with medical testing in the workplace. Section 7(2) provides as follows: *'Testing of an employee to determine that employee's HIV status is prohibited unless such testing is determined justifiable by the Labour Court in terms of section 50(4) of this Act'*. The EEA defines medical testing as including 'any test, question, inquiry, or other means to ascertain, or which has the effect of enabling the employer to ascertain whether an employee has a medical condition'.

Section 50(4) of the EEA regulates the Powers of the Labour Court when testing is declared permissible. It provides that a medical testing is justifiable only if the Labour Court declares it so. Specifically, it states that:

'if the Labour Court declares that the medical testing of an employee as contemplated in section 7 is justifiable, the court may make any order that it considers appropriate in the circumstances, including imposing conditions relating to -

(a) The provision of counselling;
(b) The maintenance of confidentiality;
(c) The period during which authorisation for any testing applies; and
(d) The category of jobs or employees in respect of which the authorisation for testing applies'

An employment policy or culture that makes it mandatory to test for HIV or any medical testing as a condition for recruitment or during employment would be rendered unfair. However, should an employer believe that such testing is important, they must seek permission from the Labour Court in terms of section 50(4) to make an order on whether such testing is justified in that particular workplace.

3.2.2. When is Medical Testing Considered Justifiable in Terms of the EEA?

The Labour Court in *Irvin & Johnson Ltd v Trawler and Line Fishing Union*[19] was requested to grant the applicant permission to conduct voluntary and anonymous testing of its workforce so that it could assess the potential

19. [2003] 4 BLLR 379 (LC).

impact of HIV in the workplace and design appropriate targeted workplace responses to facilitate the effective prevention of new HIV infections.

The court confirmed that the purpose of section 7 of the EEA is to prevent unfair discrimination against employees based on their medical condition and held that when employees are tested in such a way that the employer is unable to identify which employees are suffering from the medical condition in question, the risk of discrimination based on that condition is absent. The court also explained that when section 7(2) prohibits the 'testing' of an employee to determine employees' HIV status, what it is prohibiting is a test which is designed to enable, or which will have the effect of enabling, the employer to ascertain the HIV status of that employee. Thus, the court found that section 7, as a whole, applies to compulsory testing and not to voluntary testing. This finding was premised on the condition that testing must be voluntary; it does not matter whether testing is initiated by the employer or the employee. The court further held that, when an employee requests or voluntarily consents to an HIV test, the permission of the court is not required.

The South African Code of Good Practice: Key Aspects of HIV/AIDS and Employment[20] in dealing with HIV testing, confidentiality and disclosure provides as follows:[21]

> *'No employer may require an employee, or an applicant for employment, to undertake an HIV test in order to ascertain that employee's HIV status. As provided for in the Employment Equity Act, employers may approach the Labour Court to obtain authorisation for testing; and*
>
> *whether s 7(2) of the Employment Equity Act prevents an employer-provided health service supplying a test to an employee who requests a test, depends on whether the Labour Courts would accept that an employee can knowingly agree to waive the protection in the section.'*

In *Joy Mining Machinery Division of Harnischfeger SA Pty Ltd v National Union of Metal Workers of South Africa*,[22] the Labour Court ruled that anonymous voluntary HIV testing of employees in terms of Section 7(2) of the Employment Equity Act 55 of 1998 is legal. The Court enumerated 11 grounds that must be taken into account when performing voluntary HIV tests, including: (1) that the test to be used is the ELISA Saliva Test; (2) that at no time will the participating employee be asked his/her name, nor will such information be recorded on the sample; and (3) that the employer make it clear that it does not intend to discriminate against HIV-positive employees.

A v SAA[23] The applicant was refused employment with South African Airways after testing HIV positive in a pre-employment test. The Court held that excluding 'A' from the position of cabin attendant on the grounds of his HIV status was unjustified and awarded him compensation.

In *Nasuwu obo Zulu v Chen*,[24] the applicant, employed by the respondent as a child-minder, was dismissed after she refused to comply with the respondent's demand to undergo an HIV test. The Commissioner held that employees are not obliged to take HIV tests and that the applicant's refusal to do so was lawful. The applicant's dismissal was therefore automatically unfair.

In a more recent case of *Pharmaco Distribution (Pty) Ltd v Weideman* (JA104/2015) [2017] ZALCJHB 258 (4 July 2017), the Labour Appeal Court had to determine whether the provisions in Ms Weideman's contract of employment requiring her to undergo medical testing were enforceable. She claimed that her dismissal for failing to submit to a medical examination on her employer's instruction was automatically unfair. Ms Weideman's contract of employment was central to the issue. It provided that:

> *'The Employee will, whenever the Company deems necessary, undergo a specialist medical examination at the expense of the Company, by a medical practitioner nominated and appointed by the Company. The Employee gives his/her consent to any such medical practitioner making the results and record of any medical examination available to the Company and to discuss same with such medical practitioner. The above shall include and apply to psychological evaluations.'*

20. Published under GN R1298 in *Government Gazette* 21815 of 1 December 2000.

21. Ibid.

22. 2002 23 ILJ 391 (LC)

23. J1916/99

24..2002 5 BALR 511 (CCMA)

Ms Weideman did not attend the assessment with a psychiatrist as instructed and Pharmaco subsequently dismissed her. In the Labour Court, Pharmaco argued that its decision to insist on a psychiatric assessment of Ms Weideman was justified because she consented to undergoing a medical test when reasonably required to do so by the company in her employment contract and her behaviour and disclosure of her bipolar condition made insistence on such an assessment reasonable.

The Labour Court was not persuaded by Pharmaco's argument. The Labour Court reiterated that section 7(1) of the EEA prohibits medical testing of an employee unless permitted or required by legislation or it is justifiable in the light of medical facts, employment conditions, social policy, the fair distribution of employee benefits or the inherent requirements of a job.

The Labour Court found that Pharmaco had not met the requirements of any of the exceptions to the EEA's prohibition of medical testing. It held that employee consent does not constitute an exception to the prohibition. On this basis, the Labour Court accordingly held that the clause in Ms Weideman's contract was not permissible in terms of section 7 of the EEA and declared it unlawful and unenforceable.

The Labour Court found further that Pharmaco had unfairly discriminated against Ms Weideman in instructing her to undergo a psychiatric assessment as the instruction only arose because of her bipolar condition. Consequently, Ms Weideman's dismissal for refusing to accede to being tested was found to be automatically unfair. She was awarded 12 months' remuneration as compensation for her unfair dismissal and an amount of R15 000.00 as damages for unfair discrimination.

Pharmaco took the judgment on appeal to the Labour Appeal Court. The Labour Appeal Court found that it was abundantly clear from the evidence that but for Ms Weideman's bipolar condition, she would not have been instructed by Pharmaco to undergo a psychiatric assessment and would not have been dismissed for refusing to do so. This, the Labour Appeal Court found, amounted to unfair discrimination on the grounds of disability.

The Labour Appeal Court confirmed that "consent" is not a justification for dismissal as contemplated in section 7(1) of the EEA. Therefore, an employer cannot rely on the employee's consent in an employment contract to undergo medical testing as and when required to do so as justification for dismissal.

On the question of the compensation and damages awarded to Ms Weideman, the Labour Appeal Court found that the Labour Court's award of compensation was an insufficient deterrent to unfair discrimination and increased the compensation awarded to Ms Weideman from R222 000 to R285 000. However, it set aside the award of damages on the basis that this amounted to penalising the employer twice for the same wrongful conduct.

3.3. Occupational Health and Safety Act[25]

An employer is obliged to provide, as far as is reasonably practicable, a safe workplace. This includes an obligation to ensure that the risk of occupational exposure to HIV and TB is minimised as far as reasonably practicable.

3.4. Compensation for Occupational Injuries and Disease Act[26]

If an employee is exposed to infected blood or body fluids as a result of a workplace accident and is infected with HIV or is exposed to TB, he or she may apply for benefits in terms of Section 22 (1) of the Act.

4. The Right to Fair Labour Practice

Section 23 of the Constitution provides that everyone has the right to fair labour practices.

Section 186 (2) defines unfair labour practice as 'any unfair act or omission that arises between an employer and an employee involving –

a. Unfair conduct by the employer relating to the promotion, demotion, probation (excluding disputes about dismissals for a reason relating to probation) or training of an employee or relating to the provision of benefits to an employee;
b. The unfair suspension of an employee or any other unfair disciplinary action short of dismissal in respect of an employee;

25. No. 85 of 1993

26. No.130 of 1993

c. A failure or refusal by an employer to reinstate or re-employ a former employee in terms of any agreement; and

d. An occupational detriment, other than dismissal, in contravention of the Protected Disclosures Act, 2000 (Act No. 26 of 2000), on account of the employee having made a protected disclosure defined in that Act."[27]

An employee would be a victim of an unfair labour practice if unfairly discriminated against by the conduct of his or her employer.[28] However, conduct amounting to an unfair labour practice is not always discriminatory in nature, it may simply be unacceptable, irrelevant or invidious in nature.[29]

5. Termination of Employment Based on Workplace Discrimination

The LRA does not provide a blanket protection against termination of employment by employers. The Code of Good Practice attached to the LRA provides a guideline for employers to follow in the instance of a dismissal. The code provides that the dismissal must be fair and it lays out the proper procedure to be followed by the employer.

If the reason for the dismissal is not fair and or the procedure followed was not correct, then such dismissal constitutes an unfair dismissal. A dismissal based on discrimination on the basis of HIV or TB status is automatically deemed an unfair dismissal. The LRA permits an employer to dismiss an employee for misconduct, incapacity or operational requirements under certain circumstances.

5.1. Dismissal due to Misconduct

A dismissal for misconduct can take many different forms, however 'the legal basis for dismissal for misconduct is the same in all cases: the employees concerned are deemed to have committed a breach of a material term of their contracts or destroyed the employment relationship, which justifies its termination by the employer'.[30]

Item 7 of the Code of Good Practice: Dismissal (Schedule 8 to the LRA) sets out the procedural guidelines that render dismissal for misconduct fair. It requires that presiding officers consider:

(a) Whether or not the *employee* contravened a rule or standard regulating conduct in, or of relevance to, the workplace; and

(b) If a rule or standard was contravened, whether or not –
  (i) the rule was a valid or reasonable rule or standard;
  (ii) the *employee* was aware, or could reasonably be expected to have been aware, of the rule or standard;
  (iii) the rule or standard has been consistently applied by the employer; and
  (iv) *dismissal* [was] an appropriate sanction for the contravention of the rule or standard.

These requirements were confirmed by the LAC in *Metro Cash and Carry Ltd v Tshehla*[31] where the court found that the correct approach to determining the existence and gravity of misconduct is to address the following issues:

- Was there a rule in force?
- Was this rule fair and reasonable? In other words, did the rule perform a legitimate function in the employer's enterprise and did it do so fairly?
- Did the employee concerned know the rule or should he have known about it?
- Was the rule broken?
- The severity of the breach.

The onus of proving the existence and contravention of the rule is on the employer, who must show on a balance of probabilities that the employee is guilty of misconduct.

An important question often asked by the courts when assessing dismissals based on misconduct is: 'Was the act of misconduct sufficiently grave as to justify the permanent termination of the relationship?' *(NUM & others v Free State Consolidated Mines (Operations) Ltd.*[32]*)*

27. No. 26 of 2000

28. HIV and the Law Manual Chapter 4 page 23

29. Ibid

30. Ibid. at p. 266.

31. (1996) 17 *ILJ* 1126 (LAC) at p. 1131.

32. (1993) 14 LLJ 341 (LAC)

What the LRA and the case law demonstrate is that misconduct is a reason for termination of employment when it results in a breach of the employment contract. The breach does not arise from the fact that the employee is HIV-positive but from the employee's failure to carry out her or his employment obligations or from her or his carrying out such obligations in a manner that violates the employment contract.

5.2. Dismissal Due to Incapacity

Dismissal due to incapacity arises when an employer decides that an employee is incapable of carrying out her or his employment obligations for failing to meet the standard of work set by the employer. 'The standard of work is both qualitative and quantitative: the employer has the right to set reasonable requirements in terms of output and the standard of work required of the employee. If the employee fails to attain the standards set by the employer, the employer is entitled to terminate the contract.'[33]

The LRA distinguishes between dismissal for poor work performance and dismissal based on ill health or injury:

- Dismissal due to poor work performance arises when, despite counselling and training, the employee lacks the skill, knowledge, ability or expertise to meet the required standard.
- Dismissal due to ill health or injury arises when the employee is unable to work because she or he is ill or injured.

As with dismissal for misconduct, dismissal for poor work performance must be fair and reasonable and effected in accordance with a fair procedure.

Procedural fairness is stipulated in the in the Code of Good Practice. The LRA provides that fairness in dismissal is decided in two ways:

1. Substantive fairness (was there a 'fair' reason to dismiss the worker? was the dismissal appropriate under the circumstances?).
   - » Here, the employer must have a proper and fair reason for dismissing the worker.
   - » A 'fair' reason can be one of these:
     i. misconduct (the worker has done something seriously wrong and can be blamed for the misconduct).
     ii. incapacity (the worker does not do the job properly, or the worker is unable to do the job due to illness or disability).
     iii. retrenchment or redundancy (the employer is cutting down on staff or restructuring the work and work of a particular kind has changed).
2. Procedural fairness (was there a fair procedure before the worker was dismissed?).
   - » The worker must always have a fair hearing before being dismissed. In other words, the worker must always get a chance to give his or her side of the story before the employer decides on dismissal.
   - » The worker is allowed to refer the proposed dismissal to the CCMA for conciliation.

In *Allpass v Mooikloof Estates (Pty) Ltd t/a Mooikloof Equestrain Centre*,[34] the court held that dismissal because of HIV status is discrimination prohibited by s 187(1)(f) and is therefore an automatically unfair dismissal.

Although unreported the case of *Zungu v ET Security Service*[35] provides an example of fairness of dismissal due to incapacity. The applicant alleged that his dismissal was unfair and that, even though he had full-blown AIDS, he was still capable of performing his duties as a security guard. The CCMA found to the contrary and stated that the applicant was lawfully dismissed, that the severity of the opportunistic infection he suffered from made it impossible for him to perform his duties, and that the respondent acted in good faith.

5.2.1. Procedural and Substantive Fairness in Incapacity due to Ill Health

HIV is now considered a manageable disease while TB is curable. However, PLHIV and PWTB have right to know when it would be procedurally or substantively unfair to be dismissed due to ill health, especially if they are following HIV and TB treatment protocol.

33. J Grogan Dismissal, Discrimination and Unfair Labour Practices 2nd edn (Cape Town: Juta, 2007) at p. 23.

34. Op cit note 12.

35. CCMA case number KN50648 unreported

Dismissal of an employee who is not able to perform his/her functions due to ill health or injury will be deemed fair, provided that there is a fair reason for the dismissal (substantive fairness) and fair procedures are followed in implementing the dismissal.

5.2.1.1. Substantive Fairness

Any person determining whether a dismissal arising from ill health or injury was unfair must consider:

- Whether or not the employee is able to perform the work for which he/she has been employed; and
- If he/she is not able to perform the work for which he/she has been employed,
  - (i) the extent to which the employee is able to perform at least some work;
  - (ii) the extent to which the employee's work circumstances might be adapted to accommodate the injury/disability. Where it is not possible to adapt the employee's work environment, consideration must be given to the extent to which the employee's job description can be adapted; and
  - (iii) the availability of suitable alternative work.

There may be times when a PWTB must take treatment in hospital especially patients with Multi-Drug Resistance TB that may be contagious. In that case the **degree** of incapacity is relevant to the fairness of any dismissal. The Code of Good Practice distinguishes between temporary and permanent incapacity.

5.2.1.2. Temporary Incapacity

The general rule is that it is inappropriate to dismiss an employee who is temporarily incapacitated. There are two exceptions to this general rule: the first exception is where, the temporary nature of the incapacity notwithstanding, the employee is likely to be absent for a time that is unreasonably long in the circumstances; and the second exception is where the employee is periodically and persistently away from work for short intervals. In the latter two instances dismissal may be justified.

What amounts to *'unreasonably long in the circumstances'* depends on the nature of the work which the employee performs, the size of the enterprise, the nature of the injury, the period of the absence and the possibility of securing a temporary replacement for the ill or injured employee. An unreasonably long absence may be treated as a permanent incapacity.

5.2.1.3. Permanent Incapacity

The employer should investigate to what extent he/she is able to secure alternative employment for the employee, or adapt the duties or work environment of the employee to accommodate his/her disability.

5.2.1.4. Cause of the Incapacity

Different causes of incapacity may require different kinds of remedial action short of dismissal. For example, where incapacity is due to alcoholism or drug abuse, counselling and rehabilitation may be the appropriate alternatives for an employer to consider.

Where an employee has been injured at work, or is incapacitated by a work-related illness, the employer has a stricter duty to accommodate the employee's illness.

This would apply to health workers who acquire HIV due to needle prick exposure or get infected with TB by being exposed to PWTB at a health facility.

5.2.1.5. Procedural Fairness

The substantive and procedural aspects of a 'no-fault' dismissal are closely connected.

- The first requirement is to establish whether an employee's incapacity is temporary or permanent, and to consider alternatives to dismissal.
- The second requirement is to give an employee an opportunity to state a case in response to the employer's investigation and recommendations. In doing so, he/she may be represented by a trade union representative or co-employee.

5.2.1.6. Employer's Duties

In order for the dismissal to be procedurally fair, the employer must:

- Investigate the extent and cause of the injury or incapacity.
- Establish the likely length of the employee's absence from work (in order to determine whether it will be 'unreasonably long').
- Investigate whether the employee's work environment can reasonably be adapted to accommodate the incapacity.
- Provide assistance to enable the employee to perform his/her duties, or part thereof, where it is reasonable and possible to do so.

If necessary, the employer must accommodate the employee in alternative suitable work, even if it means that the employee's status and remuneration is altered accordingly. In order to determine, however, whether the alternative work offered to the employee is "suitable", regard must be given to the employee's current ability, skills or qualifications and previous status. It would, for example, not necessarily be regarded as "suitable" to offer the job of tea maker to an employee who was formerly employed in a managerial position and who suffered a nervous breakdown as a result of work-related stress.

An employer's duties are prescribed within the context of what is financially reasonable and possible for the employer in the circumstances, after an assessment of what is required to accommodate the employee has been made. An employer is, however, required to investigate all alternatives short of dismissal.

6. Remedies

6.1. Legislative Remedies

The LRA remedies for unfair dismissal and unfair labour practices are set out in sections 193, 194 and 195 as follows:

S193. Remedies for unfair dismissal and unfair labour practice

(1) If the Labour Court or an arbitrator appointed in terms of this Act finds that a dismissal is unfair, the Court or the arbitrator may –

(a) Order the employer to reinstate the employee from any date not earlier than the date of dismissal;

(b) Order the employer to re-employ the employee, either in the work in which the employee was employed before the dismissal or in other reasonably suitable work on any terms and from any date not earlier than the date of dismissal; or

(c) Order the employer to pay compensation to the employee.

(2) The Labour Court or the arbitrator must require the employer to reinstate or re-employ the employee unless –

(a) The employee does not wish to be reinstated or re-employed;

(b) The circumstances surrounding the dismissal are such that a continued employment relationship would be intolerable;

(c) It is not reasonably practicable for the employer to reinstate or re-employ the employee; or

(d) The dismissal is unfair only because the employer did not follow a fair procedure.

(3) If a dismissal is automatically unfair or, if a dismissal based on the employer's operational requirements is found to be unfair, the Labour Court in addition may make any other order that it considers appropriate in the circumstances.

(4) An arbitrator appointed in terms of this Act may determine any unfair labour practice dispute referred to the arbitrator, on terms that the arbitrator deems reasonable, which may include ordering reinstatement, re-employment or compensation.

S194. Limits on compensation

(1) The compensation awarded to an employee whose dismissal is found to be unfair either because the employer did not prove that the reason for dismissal was a fair reason relating to the employee's conduct or capacity or the employer's operational requirements or the employer did not follow a fair procedure, or both, must be just and equitable in all the circumstances, but may not be more than the equivalent of 12 months' remuneration calculated at the employee's rate of remuneration on the date of dismissal.

(2) The compensation awarded to an employee whose dismissal is automatically unfair must be just and equitable in all the circumstances, but not more than the equivalent of 24 months' remuneration calculated at the employee's rate of remuneration on the date of dismissal.

(3) The compensation awarded to an employee in respect of an unfair labour practice must be just and equitable in all the circumstances, but not more than the equivalent of 12 months' remuneration.

S195. Compensation is in addition to any other amount

An order or award of compensation made in terms of this Chapter is in addition to, and not a substitute for, any other amount to which the employee is entitled in terms of any law, collective agreement or contract of employment.

The employee is likely to receive compensation if:

- The employee does not want to be reinstated.
- The circumstances surrounding the dismissal would make the relationship between employee and employer intolerable.
- It is not reasonably practical for the employer to take the employee back
- The dismissal is unfair merely because the employer failed to comply with a fair procedure, but there was a good reason for dismissal

6.2. Non-judicial Remedies

6.2.1. Employment Policies

Stigma and discrimination in the workplace for PLWH and PWTB is real. Often times, PLWH are victimised and harassed by other employees and PWTB are socially excluded making it difficult for them to perform their duties in an environment that is suitable. The Code of Good Practice on Key Aspects of HIV/AIDS and Employment of 2000 in the Employment Equity Act gives a guideline to employers when developing internal policies.

6.2.1.1. Grievance Policy

An employer by law is required to have a formal grievance procedure. The procedure should tell employee whom to contact if they have an issue and should set out the steps to be taken by the employee.

The employer must then investigate the grievance and hold a formal hearing where the employee will set out their grievance. An employee can bring a colleague or union representative.

After the formal hearing, the employer must make a decision and explain to the employee what further action they will take and what further action the employee can take. Should an employee not accept the decision, they can refer the matter to the CCMA.

6.2.1.2. HIV and TB Management Policy

Employer polices must encourage the treatment of HIV and TB just as any other illness or condition in the workplace. Employers must develop reasonable prevention policies and health interventions aimed at providing support to PLHIV or PWTB, and must develop further policies and plans aimed at training and providing access to information for all employees. These policies and plans should take gender, cultural, social and economic concerns into account.

A workplace policy must:[36]

- make an explicit commitment to corporate action;
- ensure consistency with appropriate national laws;
- establish the rights of those affected;
- give guidance to managers, supervisors and occupational health services;
- help employees with HIV and TB to understand what support and care they will receive, so they are more likely to come forward for appropriate treatment;
- help to stop the spread of TB through prevention programmes; and
- assist in planning for HIV and TB control and impact management.

The fundamental human rights principle of a workplace policy are non–discrimination and confidentiality. A HIV and TB management policy should guide employees on what to do should they be discriminated against or their confidentiality breached.

6.2.2. Sectoral Determinations

6.2.2.1. The Health Sector

South African Department of Health: Health sector HIV prevention strategy, 2016.

Section 3.6 of this strategy states that, in order to have a workforce that is fully equipped to provide a comprehensive package of HIV prevention and high-quality services, staff should receive training as needed to improve their ability to provide such services to their communities. This should be done by knowledgeable staff who maintains confidentiality, who avoid discrimination, and who are responsive to the needs of patients.

6.2.2.2. Public Service

South African Department of Public Service and Administration. HIV & AIDS and TB management policy for the public service provides the following:

- Healthy and safe work environments should be created as much as practicably possible to prevent occupational exposure and transmission of HIV and TB.
- No employee or job-applicant will be expected to disclose HIV-related personal information. Access to personal data relating to an employee's HIV-status shall be bound by the rules of confidentiality, and no employer shall disclose such information without a written consent of the employee

36. WHO guidelines

- No medical testing or screening shall be required from job applicants or those in employment for purpose of exclusion from employment or work processes.
- An employee with HIV-related illnesses, like any other illnesses, will continue to work for as long as he/she is medically fit in an available, appropriate work. The department must accommodate an employee in other posts if possible.

6.2.2.3. Education

South Africa, Dept. of Basic Education: DBE National Policy on HIV, STIs and TB

The policy states that no educators, school support staff, officials or other employees of the DBE, at any level, will be discriminated against on the basis of HIV, STIs, TB or pregnancy in terms of recruitment, appointment, deployment, employment, promotion, training or benefits, or be required to undergo HIV, STI, TB or pregnancy testing as a condition of these arrangements.

Regarding wellness of employees, this policy also states that, in terms of the Employee Health and Safety (EHW) programme, counselling, treatment and psycho-social support will be available for employees living with or affected by HIV, STIs, TB or pregnancy through referral to appropriate services.

The Basic Education Sector will take all reasonable steps to accommodate the needs of educators, school support staff and officials living with or affected by HIV STI, TB or pregnancy, including enforced absenteeism for treatment, counselling or the renewal of prescribed medication, in accordance with DPSA PILIR guidelines.

Furthermore, if employees are unable to continue their normal duties on medical grounds, the rules regarding incapacity will apply and relief-educators and other relief staff and officials will be engaged to ensure the continuity of teaching and learning.[37]

6.3. Judicial Remedies

- An employee can take issues such as discrimination or dismissals to the Bargaining Counsel or the Commission for Conciliation Mediation and Arbitration (CCMA).
- The Bargaining Counsel or CCMA will try to resolve the dispute by conciliation, mediation or arbitration.
- Cases on automatically unfair dismissal and unfair discrimination will go directly to the Labour Court after conciliation at the Bargaining Counsel or CCMA.
- Employees can appeal against decisions of the Labour Court by going to the Labour Appeal Court. According to s136 (1) (b) of the Labour Relations Act, a party must request the Commission to arbitrate a dispute within 90 days from the date on which the Commission has issued the certificate that the dispute has not been resolved.

7. Specific Key Vulnerable Populations

Key populations for HIV and TB often times include people who work for the defence work, healthcare workers, mine workers and correctional services stuff, just to mention a few. These people are often affected by the stigma and marginalisation based on their status in the employment context.

7.1. South African Defence Force

The South African Defence Force is not covered by the EEA or the LRA. Members of the Defence Force rely directly on the Constitution when enforcing their rights to fair labour practices and equality.

This means that employees of the Defence force do not enjoy the benefits of the prohibition on HIV testing and other protections as offered by the LRA.[38] They can, however, still reply on the rights to equality, dignity and privacy in the Constitution.[39] In the case of *South African National Defence Force Union v Minister of Defence* 1999 (4) SA 469 CC, soldiers used section 23 to gain the right to form and join their own trade union. In this case the Constitutional Court held that the term "worker" in section 23(2) should be interpreted to include members of the armed forces.[40]

The North Gauteng High Court dealt with the rights of HIV-positive persons in the context of recruitment and

37. South Africa. Department of Basic Education. National Policy on HIV, STIs and TB for Learners, Educators, School Support Staff and Officials in all Primary and Secondary Schools in the Basic Education Sector

38. Ibid

39. Ss 9–11 of the Constitution of the Republic of South Africa, 1996.

40. http://www.rhap.org.za/wp-content/uploads/2014/05/Health-and-Democracy-the-rights-and-duties-of-health-care-workers.pdf

employment in the South African military in the following decisions:

The first of these was *SA Security Forces Union and another v Surgeon General AO*[41] *(SASFU)* where the applicant union sought to have reviewed and set aside the formulation and implementation of the military's testing policy which excluded HIV-positive persons from recruitment and deployment. The union sought a further order that, on the setting aside of the policy, the SANDF formulate a new policy within six months of the date of the court order. The matter was settled with the SANDF's agreeing that there was no medical evidence to justify a blanket ban on the recruitment and deployment of people with HIV.

Following the above court's decision, the Department of Defence indeed formulated a new policy in the form of the Department of Defence Directive (DoDD) that was issued during 2009.

The court in *Dwenga v Surgeon-General of the South African Military Health Service*[42] dealt with the constitutionality of the HIV policy of the SANDF which banned the recruitment of anyone and everyone living with HIV.[43] The background to the HIV policy in dispute follows. New recruits to the SANDF first entered the Military Skills Development System (MSDS) for a period of two years. Following successful completion of the MSDS, they could be recruited to serve in the Core Service System (CSS). Entry into the CSS was therefore dependant on successful completion of service in the MSDS and on the availability of posts in the CSS. A health classification method was used to determine whether a person could enter the MSDS or secure a CSS contract. The health classification required was a G1K1 health classification; however, no HIV-positive person had a G1K1 classification but a G2K1. Every HIV-person was automatically excluded from a G1K1 classification, irrespective of his or her health and fitness, and therefore could not enter the MSDS or secure a CSS contract. In the military the G1K1 indicated the following:[44]

- '"G" indicates whether a soldier is healthy and can participate in physical activity. The "K" shows where individuals can be deployed as well as the level of medical care they should have access to.
- "G1" indicates the soldier is healthy and can participate in any physical activity. With age and/or the prescription of chronic medication comes a downgrading to G3 or G4, where the soldier is restricted to the performance of administrative or sedentary duties.
- "K1" means the soldier can be deployed anywhere and anytime without a medical facility in the vicinity.'

The court in *Dwenga* held that the SANDF's practice of denying HIV-positive people entry into the MSDS and of denying them the possibility of a contract in the CSS without regard to their health, fitness and ability to do the work amounted to discrimination and an assault on their dignity, contrary to provision of section 9 of the Constitution

Despite making progress in the protection of employee rights in our Defence Force, the army is considered one of the most susceptible to HIV and TB infection and transmission.[45] In Southern Africa, the TB infection rates are as high as 80%. This is due to how members of the armed forces usually live and work in confined environments; how personnel may be deploy to areas with high rates of TB and the potential to be exposed to the infected local communities, or how members of the armed forces undertake physiologically stressful activities during training and operations, these (and other) factors might increase the risk of acquiring, developing and transmitting TB among military personnel. This makes the risk of being infected with TB incredibly high for members of the armed forces.[46]

7.2. Healthcare Workers

Healthcare workers (HCWs) play an indispensable role in the implementation of health policy and the provision of healthcare services. However, their rights are frequently overlooked, and many HCWs complain of poor conditions of service, long hours and low wages.[47]

41. 2008 JDR 0933 (T).

42. 2014 JDR 1974 (GP) at para. 6.

43. Ibid. at paras 1, 2, 8, 11, 15 and 24.

44. Leon Engelbrecht ' Rotation Conundrum' 14 July 2009 https://www.defenceweb.co.za/editorial/editor-column/rotation-conundrum/

45. Heinecken, Lindy, (2003). 'Facing a Merciless Enemy: HIV/AIDS and the South African Armed Forces'. *Armed Forces & Society* - ARMED FORCES SOC. 29. 281-300. 10.1177/0095327X0302900207.

46. O'Shea MK, Wilson D, Tuberculosis and the Military, BMJ Military Health 2013;**159**:190-199.

47. http://www.rhap.org.za/wp-content/uploads/2014/05/Health-and-Democracy-the-rights-and-duties-of-health-care-workers.pdf

HCWs face high HIV and TB risk, especially where resources and constrained health system do not provide adequate protection and training in the health workplace. The Occupational Health and Safety Act[48] provides that an employer must provide and maintain, as far as reasonably possible, a working environment that is safe and without risk to the health of its employees. This means that employers must make sure that the workplace is safe, and that employees are not at risk of getting infected with HIV at work.

TB fears of HCWs may also make them reluctant to treat people with TB or those at risk, resulting in stigma and discrimination in health services.

HCWs are protected by the Constitution, the National Health Act, and employment-related statute, including the Labour Relations Act, the Basic Conditions of Employment Act, and the Employment Equity Act.[49]

7.3. Miners

Social conditions outside the mines have historically been major drivers of the HIV and TB epidemics. This started with the 'circular transmission' of sexually transmitted diseases and proceeded to an increase in HIV and TB between rural areas and the mines.

This circular transmission of HIV and TB was in part the result of the labour migration system that enabled the spread of miners' HIV and TB risks to their families and home communities. More specifically, apartheid laws separated men from their wives for extended periods, fostering sex-trade in mining shantytowns in which women had few employment prospects outside sex trading – which exposed many to HIV. Women in rural areas also became exposed to sexually-transmitted diseases without knowledge or power to address the gender inequalities that heightened their risk.

The Mine Health and Safety Act, 1996 (as amended) regulates health and safety in the mining sector and gives effect to international law commitments on health and safety in the mines. It aims to protect the health and safety of persons in mines, requires employers and employees to identify and eliminate or control hazards within the working environment and makes provision for monitoring and reporting on mine health and safety. It contains detailed provisions for managing employees' health issues.

The Occupational Diseases in Mines and Works Act 1973 (as amended) provides for compensation for certain diseases contracted by persons employed in mines and works. The Act also places the obligation on an employer to meet the costs of treating an occupational disease from the date of commencement of that disease.

The Compensation for Occupational Injuries and Diseases Act 1993 provides for compensation for disablement or death caused by occupational injuries or diseases sustained or contracted by employees in the course of their duties. Research has shown that compensation system for mine workers is rife with legal and policy challenges, including the fact that mine workers receive less TB compensation than other workers.[50]

The burden of responsibility for this shortfall is being shifted between different government departments and the mining sector, and disagreements between the Chamber of Mines and the Department of Health about who should be held responsible for correcting the compensation fund's deficit have resulted in a court case that will be heard later this year.[51]

On 26 July 2019 a full bench of the Gauteng Local Division, Johannesburg, In the matter of *Nkala and Others v Harmony Gold Mining Company Limited and Others*,[52] approved the settlement agreement reached between the parties. The settlement is between the Occupational Lung Disease Working Group – representing African Rainbow Minerals, Anglo American SA, AngloGold Ashanti, Gold Fields, Harmony and Sibanye Stillwater, and a number of ex mine workers who have been diagnosed with TB.

But before the agreement could become effective, class members were given the right to opt out of the agreement if they so wished. The 90-day opt out period ended on 24 November 2019. The opt out submissions underwent an independent audit. The outcome was that

48. Act 85 of 1993

49. The Rights and Duties of Health Care Workers, p. 318 and 319. http://www.rhap.org.za/wp-content/uploads/2014/05/Health-and-Democracy-the-rights-and-duties-of-health-care-workers.pdf

50. Ehlrich R. A century of miner's compensation in South Africa. Journal of Industrial Medicine 2012.

51. http://www.aidsmap.com/news/jun-2010/south-african-gold-mines-tb-factory-activist-claims

52. 2016 (5) SA 240 (GJ) (13 May 2016).

only three class members chose to opt out, indicating that the support of class members for the settlement is almost entirely positive.

The agreement provides meaningful compensation to all eligible gold mineworkers (or their dependants) suffering from silicosis and/or who contracted work-related tuberculosis.

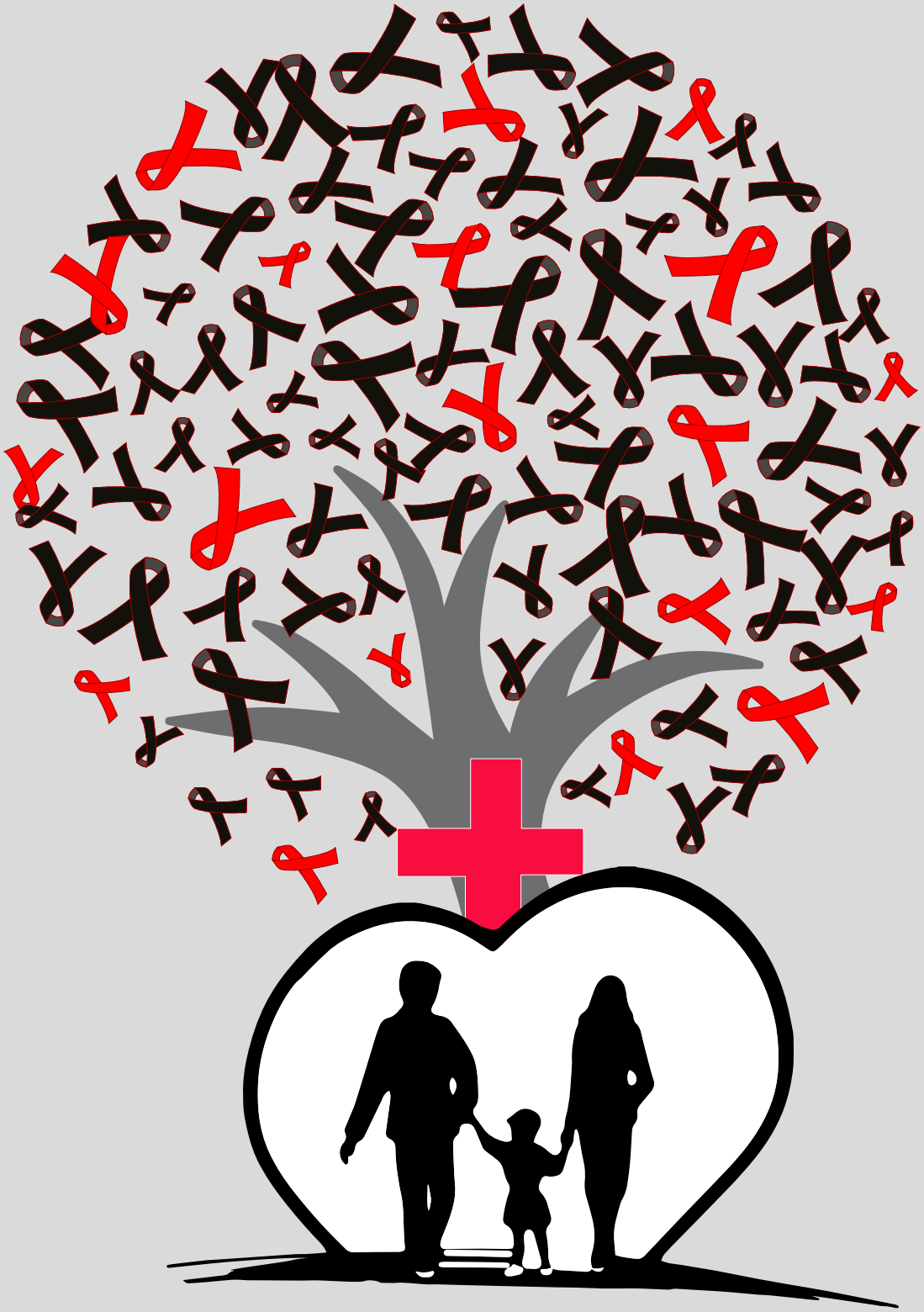
Eligibility is based on a mineworker having worked for a mine owned or managed by any of the companies that are party to the settlement at any time between 12 March 1965 and 10 December 2019.

Now that the agreement is unconditional, the Tshiamiso Trust, which will oversee the processing of claims and payment of benefits to those eligible, was registered on 28 November 2019 and the appointment of the full Board of Trustees is underway. Tshiamiso is a Setswana word meaning “to make good” or “to correct”.

Further details on the establishment of the Trust and how potential beneficiaries can establish whether they might be eligible for compensation under the Trust and, if they are potentially eligible, how to go about establishing a claim, will be made in due course.[53]

Further details regarding the claiming under the Tshiamiso Trust can be found at
https://www.silicosissettlement.co.za/

53. https://www.silicosissettlement.co.za/resources/media-releases/20-silicosis-settlement-becomes-effective-tshiamiso-trust-being-set-up



CHAPTER 7

INSURANCE LAW IN THE CONTEXT OF HIV

1. Introduction

Access to long term insurance for People living with HIV (PLHIV) has evolved over the years. Insurance companies carry out careful risk management and have embarked on continuous research and modelling to adapt to the HIV epidemic in South Africa.[1] Yet, challenges of obtaining the right cover and the costs of the cover continue to be a major hurdle for PLHIV. Determining insurance premiums for PLHIV is regarded as very complex and is influenced by gender, age, socio-economic class and geographic location.[2] This results in companies imposing rigid restrictions, terms and conditions on long term insurance for PLHIV. For example, cover may be denied if sickness, disability or death is bought about by AIDS related illness even when the death certificate records natural causes as the cause of death.

In the case of *Zurich Insurance Company v Ontario, Zurich Insurance Co v Ontario Human Rights Commission*[3] the Supreme Court of Canada stated that '[a] fundamental tension between human rights law and insurance practice exists.' What is the significance of this decision? What point does it make? In the South African context, case law on insurance discrimination is scant as cases are often settled out of court.[4]

1.1. What is Insurance?

In this context, insurance is a contract between an insurance company and an individual. It is meant to protect the person and their family from financial hardship in case something very serious, sure as an accident or unexpected death, occurs. Another way of explaining it is that insurance is a transfer of risk. You take the chance of risk (loss of income, loss of life, loss of car, health losses), and you transfer it onto an insurer, paying them a premium to insure that risk. As a consequence, if you do lose the thing that you have insured, you are covered by your policy.[5]

1.2. The Two Types of Insurance

This sections discusses the types of insurance ,namely, long term and short-term insurance.

1.2.1. Long-term Insurance

Long-term insurance is insurance that covers life-changing events, such as death, retirement and disability. The purpose of long term insurance is to provide you with an income in the long term (retirement) or a lump sum of money in the event that you become permanently disabled. It can also provide the designated parties with a lump sum of money should you pass away. Long term insurance policies include life insurance, funeral insurance, retirement annuities and endowment policies.[6]

According to the Long-term Insurance Act 52 of 1998, **'long-term policy'** means -

a) in respect of a registered insurer, an assistance policy, a disability policy, fund policy, health policy, life policy or sinking fund policy, or a contract comprising a combination of any of those policies; and includes a contract whereby any such contract is varied; and

b) in respect of a licensed insurer, a life insurance policy as defined in section 1 of the Insurance Act;

   a) on the happening of a life event, health event, disability event or death event; or

   b) on or from a fixed determinable date or at the request of the policyholder, but excludes -

      i. a deposit with an institution authorised under the Banks Act,[7] the Mutual Banks Act[8] or the Co-operative Banks Act[9]; and

1. Jason Cooper Williams "HIV and Insurance – Full Cycle in South Africa" (2014) accessed from http://www.genre.com/knowledge/blog/hiv-and-insurance-full-circle-in-south-africa.html on 4 April 2020.
2. Ibid.
3. 1992 (2) S.C.R. 321.
4. Kuschke 'Disability discrimination in insurance' 2018 De Jure 50-64 http://dx.doi.org/10.17159/2225-7160/2018/v51n1a4
5. Real People Life 'Difference between Long Term and Short Term Insurance" (4 July 2018) accessed from https://www.realpeopleassurance.co.za/difference-between-long-term-and-short-term-insurance/ on 3 April 2020.
6. Ibid
7. Act 94 of 1990.
8. Act 124 of 1993.
9. Act 40 of 2007.

ii. participatory interests in a collective investment scheme registered in terms of the Collective Investment Schemes Control Act[10] and includes a renewal or variation of that arrangement.

1.2.2. Short-term Insurance

Short-term insurance, on the other hand, is insurance that you take out on your possessions. The purpose of short term insurance is to protect you against losses that you may suffer as a result of unforeseen events such as accidents, crime, floods, fires or illness. Often, short term insurance policies tend to cover smaller claims or those things that you may change often, for example, vehicles or household items.[11]

According to the Short-term Insurance Act 53 of 1998, **'short-term policy'** means-

a) in respect of a registered insurer, an engineering policy, guarantee policy, liability policy, miscellaneous policy, motor policy, accident and health policy, property policy or transportation policy or a contract comprising a combination of any of those policies; and includes a contract whereby any such contract is renewed or varied;

b) in respect of a licensed insurer, a non-life insurance policy as defined in section 1 of the Insurance Act.

According to the Insurance Act, **'non-life insurance policy'** means any arrangement under which a person, in return for provision being made for the rendering of a premium to that person, undertakes to meet insurance obligations that fully or partially indemnifies loss on the happening of an unplanned or uncertain event, other than –

a) a life event; or

b) a death event or disability event not resulting from an accident, and includes a renewal or variation of that arrangement.

2. Insurance in the Context of Health

Risk assessment and premium discrimination is determined on the basis of health status. Before entering into an agreement, insurance companies need information from you that will help assess the risk to the company before issuing a contract. This helps the company to calculate what premiums you should pay. For example, the assessment would mean disclosing whether you smoke or whether you have diabetes, in which case you would be seen as a higher risk than a non-smoker or a person without diabetes.

In the past only a few companies offered special policies for PLHIV and most insurers would charge a high premium or limit the amount that the life of PLHIV could be insured for. However, in recent years, South African insurers have altered their perspectives on HIV. Many now treat HIV like any other insurable chronic medical condition – something only a handful of companies did previously.[12]

This is attributed to the success of antiretroviral treatment that allows PLHIV to live longer. Also, the industry can now price and underwrite the risk more accurately.[13] Now that more cover is being offered, insurance experience data is beginning to emerge. It indicates that these approaches have a positive impact on mortality and morbidity.[14]

Offering insurance to PLHIV provides much needed financial security for their families and derives social benefits through home buying and business development activity. The understanding is that as we learn more about HIV and TB, a higher number of insurers will be open to covering the risk, which would increase the scope of the mentioned benefits.[15]

10. Act 45 of 2002.

11. Act 53 of 1998.

12. Jason Cooper Williams "HIV and Insurance – Full Cycle in South Africa" (2014) http://www.genre.com/knowledge/blog/hiv-and-insurance-full-circle-in-south-africa.html.

13. ibid

14. ibid

15. Ibid

3. Insurance, Discrimination and the Constitution

At the beginning of the spread of the HIV virus in the 1990s, most insurance companies in South Africa viewed HIV as a catastrophic illness that represented a non-insurable risk. This was because key information on HIV/AIDS that would enable insurance companies to define their underwriting policies towards the epidemic was not available. Overtime, however, a better understanding of the disease and rapid medical advances have meant that PLHIV are now reaching life expectancies that are 'almost normal', provided the disease is identified early and treatment protocols are adhered to along with maintaining a healthy diet and lifestyle.

In the same breath, Insurance contracts must be consistent with the rights in the Constitution, in particular, the right to equality contained in section 9: 'No person may unfairly discriminate against another on any ground including race, religion, sex, marital status, age, disability, gender, pregnancy, ethnic or social origin, sexual orientation, belief, conscience, culture, language or birth'.

The Promotion of Equality and Prevention of Unfair Discrimination Act[16] (PEPUDA) was passed to give effect to section 9 of the Constitution and is intended to prohibit discrimination and promote equality. Section 29(1) of the Act refers to a schedule which illustrates and emphasises practices which are unfair, widespread and need to be addressed. The Act requires the State, where appropriate, to address the practices referred to in the schedule.[17]

Item 5 of PEPUDA schedule deals specifically with insurance and identifies three practices:

- Unfairly refusing to provide or make an insurance policy available on one or more prohibited grounds.
- Discriminating unfairly in the provision of benefits, facilities and services related to insurance.
- Unfairly disadvantaging a person, including unfairly and unreasonably refusing to grant services to a person, solely on the basis of HIV status.

Section 34(1)*(a)* of PEPUDA requires the Minister of Justice and Constitutional Development to give special consideration to the inclusion of HIV status as a prohibited ground of discrimination in the Act. If HIV status was a prohibited ground, any discrimination based upon HIV status would be presumptively unfair for the purposes of the Act. It would also mean that, in terms of the illustrative schedule of unfair practices, an insurer could no longer refuse to provide cover to PLHIV. However, HIV status has not yet been included in the Act as a listed ground.

The implication of section 9 of the Constitution is that should any of the factors it lists be used by an insurer as a basis for assessing risk, the use of that factor will be presumed to amount to unfair discrimination unless the insurer is able to demonstrate that such use is fair in the circumstances or that the infringement of the right to equality which is occasioned by the use of that factor falls within the ambit of the limitations clause.[18]

HIV status is not listed in section 9 of the Constitution or in the PEPUDA as a ground upon which one may not unfairly discriminate. Therefore, in instances where an individual has unsuccessful applied for insurance and believe that the insurer's refusal to provide cover was on the grounds of HIV status, the individual must demonstrate that his or her HIV status was the basis for this decision and therefore the insurance company was discriminating between risk categories thereby infringing on his or her right to equality.

4. Medical Testing in the Insurance Application Process

The procedures followed by most insurance companies is as follows:

1) Consent form

The applicant will be asked to fill in an application form. This form will probably include a consent form – the form that states that the applicant gives permission for an HIV test to take place.

16. Act 4 of 2000.

17. See item 5 of the schedule to the Promotion of Equality and Prevention of Unfair Discrimination Act for a list of these practices.

18. *President of the Republic of South Africa and another v Hugo* 1997 (4) SA 1 (CC), but see Reinecke et al. 'Insurance' at page 165.

2) Doctor details

The applicant will also be asked to give details of his/her personal doctor (The applicant's family doctor or a doctor who the applicant trusts). The results of the HIV test will be sent to this doctor, so it is important that his/her details are correctly recorded.

3) Test result

The result of the HIV test is then usually sent to a doctor employed by the insurance company. This person is usually called the 'chief medical officer'. The chief medical officer will open a file for the applicant. The file will include all medical information relevant to the application, including the results of the HIV test.

4) Positive test result – Life Register

If a test result is positive, The insurance application may be rejected. If it is rejected, the applicants name will be put in code on the LOA's Life Register as someone who has been declined insurance. This means that if they are to apply for insurance at another company, they may also be rejected. 'In code' means that the information about the applicant's HIV status will not be able to be read by anyone, except those people who know what the code is. This is done to stop unauthorised people from obtaining information on with regard to the applicant's status.

5) Positive test result – telling your doctor

If the result is positive, the applicant's personal doctor will be told in writing. This doctor is expected to contact the applicant and inform them of the result. An insurance company will not inform the applicant directly.

6) Negative test result

If the results are negative, and all the other conditions of the insurance company are satisfied, the applicant will be told that their application for insurance has been successful. The applicant's doctor is not contacted if the results are negative.

5. Consenting to Medical Tests

Insurance companies that are members of the Association for Savings and Investment SA (ASISA),[19] will provide applicants for insurance an informed-consent document[20] before any HIV test is carried out. Whether they are ASISA members or not, insurers cannot force applicants to take an HIV test, although an applicant's refusal to take an HIV test will in all likelihood result in the insurer refusing to grant cover. Consent to an HIV test must be informed and given freely. Pre-test counselling is essential for the purposes of ensuring that the consent is informed but can be waived if it is not required.

Insurance applicants who do not wish to undergo an HIV test should consult a financial advisor regarding alternative appropriate non-insurance products which may meet their needs. ASISA has made free telephonic pre-HIV test counselling available to all persons who reside within the Southern African Development Community and who apply for life insurance policies from a South African life insurer that requires HIV testing. Persons who make use of the service are required to give their name, the name of the insurance company that has requested for the HIV test and the policy number or quotation number given to them by the insurance company. The counsellors who staff the toll-free number are trained in issues relating to both insurance and HIV and AIDS.

6. Rules on Confidentiality and Disclosures in the Insurance Industry

This section discusses various rules on confidentiality and disclosures within the insurance sector.

19. ASISA is a voluntary organisation which was formed in 2008, replacing the Life Offices' Association (LOA). Most long-term insurers are members of ASISA. ASISA members are bound by the rules dictated by ASISA and by ASISA's disciplinary code and procedures and enjoy access to certain benefits and co-operation arrangements. Because of the protections which the ASISA codes of conduct afford to insured persons (many of which are discussed in the text), it is a good idea to check whether an insurer is an ASISA member before applying for cover.

20. The ASISA HIV Testing Protocol, including obligations in respect of informed consent, accessed from http://asisa.org.za/tenakaDocuments/asisa-documents/HIV%20Testing%20Protocol%20-%20June%202015.pdf. on 6 June 2020.

6.1. Non-disclosure

Confidentiality and non- disclosure to insurance companies is regulated by s59(1)(a) of the Long-Term Insurance Act and s53(1)(a) of the Short-Term Insurance Act. These provisions provide that an insurance policy cannot be repudiated on the basis of non-disclosure unless the non-disclosure was likely to have materially affected the assessment of risk underwritten by the insurer at the time of the issue or variation of the policy.

The question on materiality is whether the non-disclosure is likely to have materially affected the assessment of the risk at the time of its issue or at the time of any variation of the policy. The test for materiality is whether a reasonable, prudent person would consider that the particular information constituting the representation or non-disclosure should have been correctly disclosed to the insurer so that the insurer could form its own view as to the effect of such information on the assessment of the relevant risk.

The duty to disclose in insurance contracts arises automatically by law. Therefore, as a general rule when applying for insurance, a person has a legal duty to disclose all 'material facts' which may affect the company's assessment of their risk – in other words, you must mention all facts that can influence the company's decision to grant you insurance. In the case of *Basson v Hollard Life Insurance*[21] the defendant rejected the plaintiff's claim on the grounds of the deceased's alleged misrepresentation, and non-disclosure, of certain facts to the defendant at the time when application was made for the life policy. The court confirmed the position that an insurer has the right to void a contract of insurance not only if the proposer had misrepresented a material fact but also if he had failed to disclose one. The duty to disclose in insurance contracts arises automatically by law.

If you do not disclose all material facts, the results of this non-disclosure can result in one or more of the following scenarios:

- If you deliberately answer a question falsely, you can be charged with fraud.
- The insurer may declare the contract 'null and void' (as if it never existed) if the insurer thinks your answer would have affected the assessment of the risk.
- The insurer may also declare the contract null and void if you are negligent (e.g. make a mistake) in answering a question on a material fact.
- As a result, the insurance company might not have to pay out on the contract, even if there is a death or serious damage to property.

Of importance to PLHIV is the fact that an insurer may be unable to avoid a contract even if the insured misrepresented the facts by fraudulently failing to disclose his or her HIV-positive status provided that it can be shown that had the insurer known that the insured was HIV-positive, it would still have extended cover albeit on different terms or at a higher premium.[22]

In *Visser v 1Life Direct Insurance Ltd* [23] the Supreme Court of Appeal (SCA) had to clarify the legal position when insurers can repudiate a claim upon discovering a material non-disclosure. In this case, 1Life Direct Insurance Ltd (1Life) repudiated a life insurance policy claim after investigations revealed that the deceased had misrepresented and failed to disclose details of a pre-existing medical condition which would have materially affected the policy's risk assessment. The High Court ruled in favour of 1Life. On appeal, the Supreme Court of Appeal held that 1Life did not discharge the onus of proving the truth and accuracy of the contents of the hospital records on which it relied to prove the deceased's pre-existing medical condition. 1Life failed to lead the necessary evidence and accordingly had to pay the R3,3 million claim out and foot the legal bill for its lack of attention to the evidence. Willis JA discussed the requirements for insurers to secure a repudiation based on non-disclosure of material facts. These are that:[24]

- Insurers bear the onus of proving all the elements to justify this type of repudiation;
- The onus on insurers to defend a repudiation of this nature is extensive. It must prove that:
  - » a representation was made;
  - » the representation was untrue;

21. 2018 4 All SA 77 (GJ); See also *Jerrier v Outsurance Insurance Company Limited* (2015) 3 All SA 701 (KZP) where the court confirmed the position in relation to a duty to disclose material information at the commencement of the contract.
22. *Pillay v SA National Life Assurance Co Ltd* 1991 (1) SA 363 (D) at p. 371; *Labuschagne v Fedgen Insurance Ltd* 1994 (2) SA 228 (W) at para 239; Reinecke et al. 'Insurance' at para. 206.
23. *2015* (3) SA 69 (SCA) (28 November 2014).
24. Ibid.

- » the true facts were known to the insured when the insured responded to the insurer's questions; and
- » the misrepresentation was likely to have materially affected the policy's risk assessment at the time of issue.

The assessment of an insured's state of mind at the time of responding to the insurer's enquiries involves both objective and subjective elements to be inferred from the evidence available to the court.[25] The subjective elements include what the insured thought and understood when making the disclosures, while an objective assessment is necessary to establish whether the insured could reasonably have been expected to know that their misrepresentation would materially affect the insurer's risk assessment.[26]

Regardless of the recent and much-publicised controversy relating to non-disclosure, the duty to disclose material information stands from a legal perspective as well as a business perspective and the subject of the non-disclosure does not necessarily have to be linked to the event that leads to the claim.[27]'

The *Southern Life Association v Johnson*[28] is a case in point. In this instance, Mr Johnson applied for life and disability cover. When he applied, he was asked whether he had any blood tests done in the last five years. The applicant did not disclose that a blood test had been previously carried out on him to determine whether he had a blood disorder. The applicant was not aware that he suffered from a blood disorder. No symptoms had developed at the time of the application and the applicant believed that he was in good health. Only later, when his health got deteriorated, was when his doctor informed him what the problem was. The insurance company decided not to pay the disability cover. The court decided Mr Johnson should have disclosed the fact that he had previously had a blood test. The court ruled that the undisclosed fact was 'material' and thus the company was allowed to refuse to make any payment under the insurance policy.

6.2. Confidentiality

Section 14 of the South African Constitution provides that everyone has the right to privacy. Unlawful disclosure of private facts about a person will give rise to a delictual claim for damages.[29] In a manner similar to the healthcare industry, insurance companies have a duty to keep the health information of insurance applicants private. This duty apply even when insurance is declined.[30]

The duty of confidentiality applies to the following persons:

- prospective insurers may not use your results for any other purpose but to access the risk and must treat them with confidentiality;
- brokers and intermediaries;
- medical practitioners and laboratories-discussed above; and the life register.

It is important to record everyone involved in the application because there are always a number of people involved in dealing with an insurance application, namely, the chief medical officer, the broker, the company's accountants, and filing clerks in the insurance company. Any one of these people could become aware of an applicants HIV status, and unlawfully tell others. In cases of alleged breach of confidentiality, the applicant will have to prove who committed that breach.

25. CDH Insurance Matters "Its all about the evidence" https://www.cliffedekkerhofmeyr.com/export/sites/cdh/en/news/publications/2015/dispute-resolution/downloads/Insurance-Matters-3-June-2015.pdf

26. Ibid

27. CDH Dispute Resolution Alerts " The duty to disclose material information stands" https://www.cliffedekkerhofmeyr.com/export/sites/cdh/en/news/publications/2019/Dispute/downloads/Dispute-Resolution-Alert-6-March-2019.pdf

28. 1993 (1) SA 203

29. *Financial Mail (Pty) Ltd and others v Sage Holdings and another* 1993 (2) SA 451 (A).

30. In *Jansen van Vuuren and Another v Kruger* dealt with a doctor's duty to keep a patient's HIV status confidential and held that the disclosure by a doctor to third parties of the HIV status of a patient is an unlawful infringement of privacy. The applicant's doctor in this matter, disclosed the applicant's HIV status without prior authorisation from the applicant to two other doctors whilst playing a game of golf.

7. Exclusion Clauses

Some exclusion clauses say that the insurance company will not pay out if the company decides that the insured has died or become disabled because of HIV or AIDS. This allows the insurance company to decide what the cause of death or disability is on its own. ASISA's HIV protocol provides that no member office may use HIV/AIDS exclusion clauses for new business with effect from 1 January 2005.

8. Claiming Under Insurance Policy

Under the ordinary common-law rules, one is not even required to submit a formal claim form or to notify an insurer of a loss. It is common practice, however, for insurers to insert into the insurance contract clauses stipulating the manner in and time period within which they are to be advised of claims. Ordinarily, notice to the insurer of a claim involves notifying the insurer of the loss within a particular period of time and providing the insurer with certain particulars concerning the loss. Usually this has to be done in writing through the completion of a formal claim form. Even when the contract says nothing about the completion of a form, the insurer may request the insured to complete one.

It is particularly important to note the period of time within which the insurer requires notice of a potential claim to be given. Policies often impose on the insured strict liability to notify the insurer of the potential claim within the requisite period of time. Even if the insured is not at fault in failing to notify the insurer of the loss timeously, his or her failure to do so will constitute a breach of contract.[31] A clause imposing such liability serves an important purpose for the insurer. It enables the insurer to investigate the claim in the most favourable of circumstances and while the evidence relating to the loss is still fresh. It also allows the loss to be mitigated as early as possible. Delays in notifying the insurer of a loss may therefore result in prejudice to the insurer.

When the policy concerned is a life insurance policy, it is important that the insured notify beneficiaries under the policy of the existence of the policy, of where they can find a copy of the policy documentation after the insured's death, and of the steps they should take to notify the insurer of the death.[32]

9. Legal Remedies

Disputed claims under insurance contracts can be resolved either by way of judicial process such as litigation, arbitration or by way of negotiation, directly or indirectly with the insurer.

9.1. Insurance Ombudsman

There is an Ombudsman for short-term insurance and another for long term insurance. The Ombudsman receives complaints from policy holders and attempts to resolve them through mediation and conciliation.

The Ombudsman has jurisdiction only over the companies who have agreed to become members of the Ombudman scheme. Before taking insurance, make sure you confirm that the Insurance Company is a member of the Ombudsman scheme before taking out a cover. The Ombudsman provides a cheaper and faster means of attempting to resolve the dispute compared to litigation; it is free and can be used as an initial avenue to resolve the issue before instituting proceedings in court. However, once the ombudsman has been asked to resolve a dispute, litigation cannot be pursued until the ombudsman process is complete.

9.1.1. Process

- The complaint to the Ombudsman should be short, concise and restricted to the facts.
- It should include the name of the company, policy and copies of any important supporting documents.
- The complaint can be submitted in any South African language.
- The Ombudsman will acknowledge receipt and confirm whether the matter falls within their jurisdiction

31. *Scottish Union & National Insurance Co Ltd v Native Recruiting Corporation Ltd* 1934 AS 458; Bulldog Hauliers (Pty) Ltd v Santam Insurance Ltd 1992 (1) SA 418 (W).

32. Time clauses are not considered in any detail here because they do not pose any special or unique challenges to persons living with HIV which are different from those faced by other insured persons. For more detail on time clauses, see Reinecke et al. 'Insurance' at paras 458–460.

- The Ombudsman will investigate the complaint and it will ask the insurance company to respond to the complaint within six weeks of the request. Once the Ombudsman has considered the response, He/she may make a determination immediately or request further information.

Brokers are governed by Financial Advisory and Intermediary Services (FAIS) Act. Complaints about brokers should be submitted to the FAIS Ombudsman.

9.2 Judicial

Filing a complaint with the Insurance Ombudsman does not preclude any insured person from proceeding with litigation if they are not satisfied with the outcome of the Ombudsman. Civil claims can be instituted either in the Magistrates' Court and High Court depending on the thresholds. One can claim under an insurance policy by issuing a summons. It is not necessary to send the insurer a demand before issuing a summons although it is customary to do so. A claimant who issues a summons without first making a demand in terms of the policy risks not being able to recover his or her legal costs.

CHAPTER 8

SOCIAL ASSISTANCE IN THE CONTEXT OF HIV AND TB

1. Introduction

A social grant is a form of social assistance or support that the government provides for people who are too young, sick, old or injured to look after themselves. Providing social assistance through old age pension, child support, disability, care dependency, and foster care grants is done to alleviate poverty.[1] In South Africa, social grants have become a source of income for many due to high levels of poverty and the high rate of unemployment. In relation to HIV and the TB epidemic, social grants can play a very important role in mitigating the socio-economic impact of these diseases.[2] Many people living with HIV (PLHIV) and those with TB (PWTB) are able to work and support themselves. However, if PLHIV and PWTB become sick and unable to work, they can apply for social assistance. Section 27 (1) (c) and (2) of the Constitution of South Africa provides that *'everyone has the right to have access to social security, including, if they are unable to support themselves and their dependants, appropriate social assistance. (2) The State must take reasonable legislative measures, within its available resources, to achieve the progressive realisation of these rights.'*

The Social Assistance Act 13 of 2004 read with the South African Social Security Agency Act 4 of 2004 give effect to section 27 of the Constitution by providing for the rendering of social assistance to eligible citizens of South Africa. The citizens of South Africa also includes permanent residents.

This was confirmed in *Khosa and Others v Minister of Social Development*[3] and Others, Mahlaule and Another v Minister of Social Development where the Constitutional Court had to consider an application for an order confirming the constitutional invalidity of certain provisions of the Social Assistance Act which limited eligibility for non-contributory social assistance grants to South African citizens. The applicants were a group of destitute South African permanent residents of Mozambican origin. This group was ineligible to access the various social assistance grants due to the citizenship requirement. The applicants argued that the provisions of the Act violated the right of everyone to have access to social assistance provided for in 27(1)(c) read with (2) and the right against unfair discrimination provided in section 9(3). The Court ruled that the exclusion of South African permanent residents from State social assistance programmes was irrational. In reaching this finding, the Court was guided by the impact of the exclusion on the applicants' right to equality. The right to social security, the Court held, vests in everyone and the exclusion of permanent residents from the State's social security programme affected the applicants' rights to dignity and equality. Accordingly, the Court held that without sufficient reason being established to justify such an impairment of the applicants' equality rights, the exclusion was irrational and unconstitutional.

2. Social Grants Available to People Living with HIV and Those with TB

The Social Assistance Act 2004 defines a disabled person as an adult who is 'owing to his or her physical or mental disability, unfit to obtain, by virtue of any service employment or profession, the means needed to enable him or her to provide for his or her maintenance'.

There are three primary grants which may be available to PLHIV or PWTB:

2.1. Disability Grants

A disability grant is available to people who sustain disabilities which leave them unable to earn an income. It is aimed at relieving the living conditions of people living with disabilities and health constraints and is designed to reach and assist households with lower incomes, higher rates of adult unemployment and longer periods of exclusion from the labour force than those of non-recipient households.[4] In order to receive a disability grant, you must have a physical or mental disability that prevents you from generating income or obtaining employment. Thus, this type of grant is only available to adults from the age of 18 to 59 years of age (that is, of working age) who have a physical or mental disability which makes them unfit to work for a period of longer than six months.

1. Frikkie Booysen (2004) Social grants as safety net for HIV/AIDS-affected households in South Africa, SAHARA-J: Journal of Social Aspects of HIV/AIDS, 1:1, 45-56 at 47.
2. Ibid
3. 2004 (6) SA 505 (CC); 2004 (6) BCLR 569 (CC)
4. MM de Paoli, EA Mills and AB Grønningsæter 'The ARV roll out and the disability grant: A South African dilemma?' *Journal of the International AIDS Society* 15 (2012): 1–10, at p. 2.

There are two types of disability grants:

- Permanent: This grant is valid for a period of five years after which period it may be reviewed.
- Temporary: This grant is valid for six to twelve months.

A permanent disability grant is approved if the disability will continue for more than a year. While a temporary-disability grant is approved if the disability will last for a continuous period of not less than six months but not more than twelve months. However, a permanent-disability grant does not mean that the recipient will receive the grant for life but only that it will continue for longer than twelve months.

2.1.2. Eligibility Criteria

Section 9 of the Social Assistance Act[5] provides the criteria for assessing whether a person qualifies for a disability grant. According to the Social Assistance Act Regulation 3, the regulations relating to the application for and payment of social assistance expands on these criteria. To be eligible for a disability grant the applicant:

- must be a South African citizen, permanent resident or refugee;
- must be resident in South Africa;
- must be 18 to 59 years of age;
- must have his or her disability confirmed by a medical assessment not older than three months at the date of application;
- must be unable to enter the open labour market or to support himself or herself 'in light of his or her skills and ability to work';
- must not 'unreasonably refuse to accept employment which is within his or her capabilities and from which he or she can generate income to provide fully or partially for his or her maintenance';
- may not, without good reason, 'refuse to undergo the necessary medical or other treatment recommended by a medical officer';
- must not be maintained or cared for in a State institution; and
- must not be in receipt of another social grant in respect of himself or herself.

In addition, the applicant must satisfy a means test. Currently, that means that the applicant must not earn more than R69 000 (R5 750 per month) if he or she is single or R138 000 (R11 500 per month) if he or she is in a spousal relationship.[6]

2.2.2. Medical Assessments

PLHIV qualify for and receive a temporary disability grant, based on an assessment of the disability by a State-doctor. The assessment of disability rests with the doctor who is usually guided by the person's CD4 count (less than 200) and or TB pneumonia related illness. People with a CD4 count of below 200 will usually qualify for a disability grant. At the same time, some people with CD4 counts of less than 200 may still be assessed as fit enough to work. Equally some people with CD4 counts above 200 who are very sick with TB may qualify for the grant.[7]

An applicant must first be assessed and diagnosed by a medical practitioner recognised by the South African Social Security Agency (SASSA). The medical practitioner will assess the applicant and make a recommendation to SASSA about whether the applicant's impairment is severe enough to qualify for a disability grant. A general rule is that the mere presence of HIV or TB does not qualify one for a disability grant; the applicant will qualify for a disability grant only if the disease actually renders him or her disabled. This means that an applicant is subject to a medical assessment which must produce a finding that the applicant is disabled as a result of his or her disease.

2.1.3. Inconsistencies in the Medical Assessment Process

The process of regulating and monitoring access to the disability grant has proven to be challenging and controversial. The lack of training and clear guidelines provided to medical practitioners tasked with the medical assessment of grant applicants has led to ambiguity and uncertainty in the disability grant assessment process.[8]

5. Act 13 of 2004.
6. In this regard, reg 1 defines spouse as 'a person who is the spouse or partner of a person in accordance with the Marriage Act, 1961 (Act No. 25 of 1961), the Recognition of Customary Marriages Act, 1998 (Act No. 120 of 1998) or the Civil Union Act 2006 (Act No. 17 of 2006) or the tenets of any Asiatic religion'.
7. Govender, V., Fried, J., Birch, S. *et al*. Disability Grant: a precarious lifeline for HIV/AIDS patients in South Africa. *BMC Health Serv Res* **15**, 227 (2015) accessed from https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-015-0870-8#citeas on 3 July 2020.
8. Ibid. at p. 18.

Moreover, evidence suggests that medical practitioners in many instances feel pressured by HIV-positive patients and use the disability grant as a poverty-alleviation intervention, approving grants on the basis of socio-economic need rather than clinical or medical criteria only.[9] In contrast, there are medical practitioners who refuse to consider socio-economic circumstances in their assessment of an individual's disability grant eligibility. Therefore, the rationale for recommending grants differs from doctor to doctor which leads to inconsistencies in the assessment process.[10] 'Disability' is not defined in the Act or its regulations and the lack of a proper definition means that it remains open to interpretation.[11]

Medical practitioners are also often unsure whether to recommend that an applicant receive a permanent or a temporary grant. The regulation of these categories of grant changes frequently. As a result, doctors often recommend that a temporary grant be awarded, contrary to the regulations, in order to avoid erroneously recommending a permanent grant and the resultant burden on the State. This means that many people who should receive permanent grants are given temporary ones.[12] This in turn means that they have to reapply for a disability grant annually, thus increasing the administrative burden on SASSA.

2.1.4. Incentive to Remain Ill

The Community Agency for Social Enquiry (CASE) was appointed in 2004 by the National Treasury to conduct an investigation into the reasons for the sudden rise in the number of disability grant recipients.

CASE researchers found that poverty and unemployment were frequently named as reasons for the upsurge in the number of disability grant applicants and recipients: 'The perception that the disability grant is viewed as a form of poverty alleviation by both applicants and some involved in the assessment and approval process was almost universal'.[13] The research thus indicates that HIV/AIDS and TB acts as a vital source of income for many individuals who live in poverty.

This was confirmed by a representative of the National Association of People with AIDS who stated that 'HIV-positive people who had not yet become 'sick enough' to qualify for the disability grant start 'neglecting themselves' in order to 'qualify for government grants to put bread on the table'.[14] The representative highlighted the importance of creating better employment opportunities for PLHIV. The burden being placed on the disability grant to act as a poverty alleviation mechanism is onerous and is bolstered by the increased desperation amongst adults of working age who cannot access social assistance.

In a study done by the BMC Health Research,[15] patients confirmed the role of the grant in enabling them to pay for transport fees to the facilities and confirmed that once the grant was stopped because they were now 'healthy', they struggled to access treatment because of transport constrains.

2.1.5. The Means Test

Even if you qualify for a grant, you will not automatically receive the full amount available. The Department of Social Development uses a formula called 'the means test' to work out how much financial support a person should receive, meaning the more income you have, the less you will receive, thus preventing the exploitation of the grant system.

The disability grant is designed for working-age adults, and a person is eligible only if the degree of his or her disability makes him or her incapable of entering a labour market. The applicant must not refuse to accept employment which is within his or her capabilities, or to receive treatment which may improve his or her condition.

9. 10 N Nattrass 'Disability and welfare in South Africa's era of unemployment and AIDS', CSSR Working Paper No. 147 (2006), at p. 9, available at http://www.cssr.uct.ac.za/sites/cssr.uct.ac.za/files/pubs/wp147.pdf.
10. Op cit note 4 at p. 6.
11. G Kelly 'Hard and soft medicine: Doctors' framing and application of the disability category in their assessments of grant claimants' fitness to work in South Africa' CSSR Working Paper No. 384 (2016), at p. 8, available at https://open.uct.ac.za/bitstream/handle/11427/21584/Kelly_Working%20Paper%20384_2016.pdf?isAllowed=y&sequence=1
12. Ibid.
13. Op cit note 10 at p. 5.
14. Ibid.
15. Op cit note 7.

Regulation 19(1) of the regulations[16] provides that '[f] or the purposes of determining means, in respect of social assistance, except for a grant in-aid and the foster child grant, the income of the applicant is deemed to be the annual income for an applicant not in a spousal relationship, or half the annual income of the applicant and his or her spouse'. The income threshold for the purposes of the means test has been R6 510 per month and the asset threshold R1,115,400 for single persons. The income threshold for persons in a spousal relationship is a combined amount of R13,020 per month whilst the asset threshold is R2,230,800.[17] The full grant of R1,860 per month from April 2020 is awarded to applicants with an income below the so-called 'disregard' level of R1 860 per month.[18] The grant level decreases at higher income levels up to and including the threshold above which applicants do not qualify for the disability grant. Should the couple be estranged but still married, the grant applicant can provide an affidavit to that effect and still qualify for the grant if the spouse's income would otherwise disallow him or her the grant.

Antiretroviral (ARV) and TB treatment have the effect of improving health for PLHIV and PWTB and can in turn affect their grant eligibility. However, research shows loss of income when disability grants are not renewed had a substantial impact on both the individual living with HIV and the household.[19] Therefore, it is important to provide 'sustainable economic support in conjunction with ARVs in order to make 'positive living' a reality for PLHIV'.[20] It is argued that a chronic illness grant or a basic income grant or an unemployment grant could provide viable alternatives when the PLHIV are no longer eligible for a disability grant.[21]

2.2. Care-dependency Grants

Section 28(1)(c) of the Constitution provides that every child has the right 'to basic nutrition, shelter, basic healthcare services and social services.' Children with HIV and TB, especially children with AIDS-related illnesses, qualify for a care dependency grant. This grant is available only to children whose physical condition prevents them from attending school. The child must be in the full-time care of a care-giver at home. A child living permanently in a psychiatric hospital, or a care or rehabilitation centre, does not qualify for a care-dependency grant.

The care-dependency grant was introduced as a poverty-alleviation strategy. Even though it is supposed to be used for the benefit of children, it also meets the needs of other members of the household. It is important that it be used in the best interest of children, since they are the intended beneficiaries. Based on the research findings of caregivers in Ba-Phalaborwa district in Limpopo, it is concluded that the grant is utilised to benefit children directly by paying for food, clothes for children, school-related needs such as school uniforms, Early Childhood Development centres and transport. Indirectly, though, the grant benefits other family members as well.[22]

Section 7 of the Act provides that a person is eligible for a care-dependency grant if he or she is a parent, primary care giver or foster parent of a child who requires and receives permanent care or support services due to his or her physical or mental disability. Section 6(1) of the regulations provides that *'a parent, primary care giver, or foster parent is eligible for a care dependency grant in respect of a care dependent child if a medical officer certifies the child as a care dependent child as defined in the Act'*. A care dependent child is a child who requires and receives care due to his or her severe mental or physical disability.

For example, a child who has a mental disability that prevents them from attending school, including remedial school, and relies on a care giver for daily activities is a care-dependent child.

16. Op cit note 5

17. Gabrielle Kelly 'Everything you need to know about Social Grants' accessed from https://www.groundup.org.za/article/everything-you-need-know-about-social-grants_820 on 6 June 2020.

18. Ibid.

19. Op cit note 4 at page 4.

20. Ibid.

21. Ibid

22 P Khoza and E Kaseke 'The utilisation of the child support grant by caregivers: the case of Ba-Phalaborwa municipality in Limpopo Province' Social work 2017, vol.53, n.3, pp.356-367 accessed from http://www.scielo.org.za/scielo.php?script=sci_arttext&pid=S0037-80542017000300006

2.2.1. Eligibility Criteria

Section 7 of the Social Assistance Act provides that a person is 'eligible for a care-dependency grant if he or she is a parent, primary care giver or foster parent of a child [i.e., a person under the age of 18 years] who requires and receives permanent care or support services due to his or her physical or mental disability', but is not eligible for such a grant 'if the child is cared for on a 24-hour basis for a period exceeding six months in an institution that is funded by the State'.

Regulation 8 of the regulations to the Social Assistance Act[23] sets out additional requirements that must be met to establish eligibility for a care-dependency grant. It reads as follows:

In addition to the requirements contemplated in section 7 of the Act, a parent, primary care-giver or foster parent is eligible for a care-dependency grant in respect of a care-dependent child if –

(a) an assessment confirms that the child, due to his or her physical or mental disability, requires and receives permanent care or support services;

(b) he or she meets the requirements of the financial criteria set out in Annexure D [to the regulations]; and

(c) he or she is a South African citizen, a permanent resident or a refugee.

2.2.2. The Means Test in 2020

As with applications for the disability grant, applicants for a care-dependency grant must also satisfy a means test in order to qualify for the grant. As of April 2020, the value of Care Dependency Grant is R1,860 per month.

The income threshold of the means test is R16 900 per month for single persons and a combined income of R33 800 per month for persons in a spousal relationship.[24]

2.2.3. Medical Assessments

Applicants for a care-dependency grant are also required to submit a medical report confirming that the child concerned is severely disabled and receives permanent care or support services. However, owing to the vague eligibility criteria, medical practitioners use their own discretion when determining eligibility. As a result, the assessment test tends to be very subjective.[25] Hence, there is no standardised assessment procedure that is consistently applied amongst all medical practitioners.

As is the case with the disability grant assessment procedure, there is a lack of training and guidelines available to medical practitioners. Currently the assessment is based on purely medical grounds which is problematic in that it does not take into account 'the costs of the required medical treatment, the level of care required (hours and intensity), the costs of assistive *[sic]* devices, specialised clothing and nutritional needs, transport costs and the need for special schooling'.[26]

2.3. Grants-in-aid

People who are too ill to care for themselves at home are entitled to apply for this grant. A Grant-in-aid recipient is provided with nursing care. The Grant-in-aid is an extra grant for people receiving disability, older persons or war veterans' grants who, because of their mental or physical disabilities, are unable to look after themselves and need to pay a full-time caregiver. In order to receive this grant, you will need to be assessed by a medical officer. You cannot receive this grant if you are being cared for in a State institution. The value of Grant-in-aid is R430 per month.

Disability grants and care-dependency grants are the two grants most frequently applied for by people living with HIV or TB.

23. Op cit note 5.

24. Department of Social Development 'Asset and income threshold 2013', available at http://www.dsd.gov.za/index.php?option=com_docman&task=cat_view&gid=103&Itemid=39 (accessed 18 February 2015).

25. 'Issue paper on social security for children in South Africa', prepared for the Commission of Enquiry for a Comprehensive Social Security System in South Africa by the Child Health Policy Institute and Black Sash (2000) at p. 7, available at http://ci.org.za/depts/ci/pubs/pdf/poverty/workpap/issue.pdf.

26. Ibid.

2.4. The Chronic Illness Grant

The Chronic Illness Grant, also known as the Chronic Disease Grant, is available to all people living with chronic illnesses. A chronic illness is one that is long-lasting but manageable with the right treatment and lifestyle.[27] The chronic illness grant would aid in realising the right to health as it would enable people 'to properly manage their HIV and TB through good nutrition, regular visits to clinics and medication. Evidence shows that grants are indeed spent on such essentials in our country, despite common beliefs that people waste their grant money. If people are able to properly take care of themselves, the growing burden on the public health system will decrease.'[28] Furthermore, the tendency of people to discontinue treatment in order to remain ill so that they may continue to access the disability grant would be prevented.

3. Suspension and Lapsing of Grants

A grant may be suspended:[29]

- if SASSA was given false information (fraud or misrepresentation); or
- if the grant was approved in error.

A disability grant will lapse:[30]

- on the last day of the month in which the beneficiary dies;
- on the beneficiary's admission to a State-funded institution;
- if the grant is not claimed for three consecutive months;
- when the period of temporary disability has expired;
- when the beneficiary is absent from South Africa for a period longer than 90 days; or
- when the beneficiary ceases to be a refugee.

A care-dependency grant will lapse:[31]

- on the last day of the month in which the care-dependent child dies;
- on the last day of the month in which the care-dependent child attains the age of 18 years and becomes eligible for a disability grant;
- on the first day of the seventh month following the date on which the care-dependent child was admitted to an institution funded by the State; or
- If a parent, primary care-giver or foster parent ceases to be a refugee.

4. Appeal Procedure for Unsuccessful Grants Applicants

Should an application for a disability grant be declined, the applicant or a person acting on his or her behalf may apply to SASSA in terms of section 18(1) of the Social Assistance Act requesting that it reconsider its decision.[32] The application form is available at all SASSA offices.

The following should be attached to the completed application form:

- any document provided by SASSA as proof of receipt of an application for social assistance;
- a copy of SASSA's letter of rejection of the application for social assistance; and
- any other document relevant to the application.

When a person applies on behalf of the beneficiary or applicant, a copy of the power of attorney or proof of his or her appointment by the applicant or beneficiary to act on the latter's behalf must also be attached.

The SASSA agency cannot unreasonably delay a decision on application. The Court made it clear in

27. G Silber 'A chronic disease grant for South Africans' Equal Treatment 27 (June 2009): 5–6 at p. 5.
28. Ibid.
29. Reg 29(1) of the 'Regulations relating to the application for and payment of social assistance and the requirements or conditions in respect of eligibility for social assistance'
30. Reg 28(1).
31. Reg 28(4)*(a)*.
32. Reg 2(1) of the 'Regulations relating to the lodging and consideration of applications for reconsideration of social assistance application by the Agency and social assistance appeals by the Independent Tribunal', published under GN R746 in Government Gazette 34618 of 19 September 2011.

Mbanga v MEC for Welfare and Another[33] where it held that it was reasonable for a decision on an application for a social grant to be taken within three months and that it was unreasonable for SASSA to have taken thirty two months to approve the application. Accordingly, the Court held that failure to take a decision on a social grant application constitutes an infringement of the applicant's constitutional right to lawful and just administrative action.

Similarly, in the *Ngalo v South African Social Security Agency*[34] the Applicant was the mother of a disabled minor who applied to SASSA for a care dependency grant. A year lapsed without a response to that application. She again made another application for care dependency grant on 20 January 2011 but still no response came from SASSA. On 1 September 2011 her attorneys wrote a letter to the Regional Executive Manager of SASSA requesting the outcome of the application. Again, no response was received from SASSA. The court held that the delay of over two years in processing the application was unacceptable as it prejudices the Applicant.

A reconsideration application must be lodged with SASSA or delivered by hand, post, fax or electronic mail. It is recommended that the applicant provide SASSA with medical evidence or any supporting documents such as clinic cards in support of the application for reconsideration. SASSA must, within 90 days of receiving the application, uphold, dismiss or vary its decision. If SASSA decides to dismiss its earlier decision, it must provide reasons for the dismissal.

SASSA often requests further information from the grant applicant prior to taking a decision on the application. This additional information may take the form of a report from an occupational therapist, physiotherapist or dietician. Grant applicants are advised to secure these reports from their nearest State hospital.

If the application for reconsideration is dismissed, the applicant may lodge an appeal to the Independent Tribunal on Social Assistance Appeals established in terms of section 18(2)(b) of the Social Assistance Act.

The appeal must be lodged within 90 days of the applicant being notified of the rejection of his or her application for social assistance. Appeal forms should also be readily available at all SASSA offices. If one has missed the 90-day cut-off, one can submit an 'Application for Condonation for Late Appeal' in which you explain why your appeal is late. The Tribunal must decide within 90 days whether they'll accept the late appeal.[35]

The following should be attached to the completed appeal form:

- proof of the grant application to SASSA (receipt issued by SASSA),
- previous and current medical reports,
- proof of income (assets are not taken into account in applications for care-dependency grants),
- SASSA's letter of notification of decision (the rejection letter), and
- any other supporting documentation.

Appellants may also appoint a representative to lodge appeals on their behalf in which case a power of attorney must also be attached to the appeal form. If the Tribunal rejects the appeal without any lawful and reasonable grounds, one can approach a court of law to overturn the Tribunal's decision based on the Constitutional right to just administrative action.

The Social Assistance Amendment Bill [B 8B-2018]is before Parliament and seeks to, *inter alia*, remove the reconsideration mechanism within SASSA and allow for direct access to an appeal to the Tribunal regarding a grant application or review by SASSA.[36]

33. 2001 (8) BCLR 821

34. *Ngalo v South African Social Security Agency* (SASSA) (2740/11) [2013] ZAECMHC 4; [2013] 2 All SA 347 (ECM) (14 February 2013)

35. Regulation 15.

36. https://pmg.org.za/committee-meeting/30998/

CHAPTER 9

HARMFUL CULTURAL PRACTICES AND HIV

1. Introduction

Traditional cultural practices reflect values and beliefs held by members of a community for periods often spanning generations.[1] These customs and traditions of communities have led to the development of customary law which fulfills a purpose for those that practice it.[2] Different ethnic groups in South Africa have specific traditional cultural practices and beliefs, some of which are beneficial to all members, while others are harmful to a specific group such as women and girls.[3] The most common harmful traditional cultural practices amongst various ethnic groups include polygamy, male primogeniture, child marriages, female genital mutilation, male circumcision rituals, Ukuthwala and virginity testing. These cultural practices increase vulnerability to human immunodeficiency viruses (HIV).[4]

2. Constitutional Provisions Governing Customary Law

Despite the negative effect of some cultural practices, customs are still very important to most people in South Africa, controlling areas of their lives including marriages, property, and the right to inherit. Hence, customary law had to be recognised and incorporated into the post-apartheid democratic dispensation. The Constitution of the Republic of South Africa, 1996 recognises customary law as a legal system. The basis for recognising customary law derives from the constitutional rights to culture. These rights are contained in sections 30 and 31 of the Bill of Rights. Section 30 provides that all persons have the right to 'participate in the cultural life of their choice,' while section 31(1) provides that: 'Persons belonging to a cultural, religious or linguistic community may not be denied the right, with other members of that community, to enjoy their culture, practise their religion and use their language.'

Sections 211(1) and (2) and 212 of the Constitution acknowledges the communal nature of cultural leadership by recognising traditional leaders and providing for their role in communities that practice customary law. Section 211 state that:

'(1) The institution, status and role of traditional leadership, according to customary law, are recognised, subject to the Constitution.

(2) A traditional authority that observes a system of customary law may function subject to any applicable legislation and customs, which includes amendments to, or repeal of, that legislation or those customs.

Section 212 provides that:

'(1) National legislation may provide for a role for traditional leadership as an institution at local level on matters affecting local communities.

(2) To deal with matters relating to traditional leadership, the role of traditional leaders, customary law and the customs of communities observing a system of customary law —

(a) national or provincial legislation may provide for the establishment of houses of traditional leaders; and

(b) national legislation may establish a council of traditional leaders.'

In *Mthembu v Letsela*, the High Court confirmed that 'customary law has been accepted by the framers of the Constitution as a separate legal and cultural system which may be freely chosen by persons desiring to do so'. In *Gumede v The President of the Republic of South Africa*, the Constitutional Court confirmed that customary law 'lives side by side with the common law and legislation'.

When it comes to customs and usages of a cultural group as a source of customary law, the requirements for proving existence of a custom or usage through the lens of common law are as follows:

- The custom or usage must have been in existence for a long period;
- The relevant community must generally observe the custom or usage;
- The custom or usage must be reasonable; and
- The custom or usage must be consistent with or subject to the Constitution and other legislation.

1. MJ Maluleke 'Culture, Tradition, Custom, Law and Gender Equality' PER / PELJ 2012(15)1 accessed from http://www.scielo.org.za/pdf/pelj/v15n1/v15n1a01.pdf on 19 April 2020.
2. M Mswela 'Cultural practices and HIV in South Africa: a legal perspective' PER 2009(12)4 accessed from http://www.scielo.org.za/pdf/pelj/v12n4/a07v12n4.pdf on 20 April 2020.
3. Op cit note 1 at pg 2/428.
4. Op cit note 2 at 175/360.

The exercising of the cultural rights as articulated above cannot be inconsistent with any other rights in the Bill of Rights. That is 'the practice of culture cannot undermine any basic human rights'[5] to equality and dignity. If there is a conflict between customary law or culture with human rights, the fundamental human rights articulated in the Constitution prevail.

3. Traditional Customs and HIV

3.1. Harmful Cultural Practices and Violation of Constitutional Rights

Harmful cultural practices can be defined as 'all practices done deliberately by human beings on the body or the psyche of other human beings for no therapeutic purpose, but rather for cultural or socio-conventional motives and which have harmful consequences on the health and the rights of the victims.'[6] As previously indicated, in South Africa, practical examples of traditional practices that promote discrimination and inequality and increase HIV infection are polygamy, male primogeniture, child marriages, female genital mutilation, male circumcision rituals, Ukuthwala and virginity testing. These traditional cultural practices are both harmful, especially to women and girls, and violate the rights in the Constitution.

These harmful cultural practices violate the following rights in the Constitution:

- Section 9, which provides for the right to equality and prohibits discrimination based on gender, sex, pregnancy, marital status, sexual orientation and culture.
- Section 10, which provides for the right to human dignity.
- Section 11, which protects the right to life.
- Section 12(1), which provides for the right to freedom and security of the person – including freedom from all forms of violence, and the right not to be treated in a cruel, inhuman and degrading way.
- Section 12(2), which provides for the right to bodily and psychological integrity – including the right to make decisions concerning reproduction and the right to security in, and control over, one's body.
- Section 27(1)(a), which provides for the right to sexual and reproductive healthcare. It states that: 'Everyone has the right to have access to healthcare services including reproductive healthcare.' It has been opined that this right '…entitles both women and men to have the freedom to decide if and when to begin a family and the right to be informed of and to have access, if they choose, to safe, effective, affordable, and acceptable family planning.'

3.2. Harmful Cultural Practices and the Link to HIV

3.2.1. Polygamy

The traditional practice of polygamy allows men to have more than one wife. It survives, despite the fact that international human rights instruments define equality in marriage and family life in terms of a framework of equal rights and responsibilities.[7] It is this framework of equality in rights and responsibilities that is violated in polygamous unions in that wives have fewer *de facto* marital rights and their husbands fewer responsibilities.[8]

Polygamy creates concurrent sexual arrangements within marriage between multiple wives and their husband in addition to any extramarital sexual contacts a spouse may have.[9] Direct sexual transmission of HIV can occur in these relationships when one of the partners to the polygamous union is HIV-positive or when the virus is introduced through one of the spouses' extramarital sexual contacts. Formal legal recognition of polygamous unions reinforces the patriarchal notion that women should passively accept their husband's sexual decision-making and broadens the scope of masculine

5. Devon Hall 'Customary Law in South Africa: Historical Development as a Legal System and its Relation to Women's Rights' South African History On line accessed on https://www.sahistory.org.za/article/customary-law-south-africa-historical-development-legal-system-and-its-relation-womens.
6. Mubangizi, John Cantius (2015). An Assessment of the Constitutional, Legislative and Judicial Measures against Harmful Cultural Practices that Violate Sexual and Reproductive Rights of Women in South Africa. Journal of International Women's Studies, 16(3), 158-173 also available at: http://vc.bridgew.edu/jiws/vol16/iss3/11.
7. L Kelly 'Polygyny and HIV/AIDS: A health and human rights approach' *Journal of Juridical Science* 31 (2006): 1–38 at p. 3.
8. SD Ross 'Polygyny as a violation of women's right to equality in marriage: An historical, comparative and international human rights overview' Delhi Law Review 24 (2002): 22–40 at p. 34.
9. Kelly (fn. 44 above) at p. 3.

sexual freedom.[10] Studies have shown that, in addition to reinforcing patriarchy, polygamous relationships are characterised by friction and disagreement between co-wives and aggravates domestic violence in husband–wife relationships.[11]

These strong patriarchal notions increase the risk of HIV transmission by undermining women's ability to negotiate condom use, to insist on partner fidelity, and to leave high-risk sexual relationships.[12] Negotiating safe sexual practices and insisting on partner fidelity are further complicated in polygamous households by the fact that multiple wives are often reliant on one husband for economic survival.[13]

3.2.1.1. Regulation of Polygamous Marriages in South Africa

Under apartheid, customary unions did not enjoy the same legal status as that of civil marriages. This discriminatory practice was remedied by the enactment of the Recognition of Customary Marriages Act[14] (RCMA), which became law on 15 November 2000. The Act also recognises polygamy.[15]

The Act creates a set of rules governing customary marriages and creates certain legal obligations and protections for parties to the marriage. It also sets out the rules for a proper customary marriage: both parties must be over the age of 18, both must consent to be married under customary law and the marriage must be valid under the relevant provisions of customary law.[16] The Act gives full legal recognition to customary marriages[17] and gives all partners to a customary marriage equal status and legal capacity within the marriage, including the capacity to acquire and dispose of assets, enter into contracts and litigate.[18]

Customary marriages are automatically in community of property unless the parties enter into an antenuptial contract.[19] The RCMA also provides that customary marriages can be dissolved by an order of court only and that the provisions of the Divorce Act[20] and the Mediation in Certain Divorce Matters Act[21] apply to customary marriages.[22] A woman who wishes to end a polygamous marriage is entitled to claim her share of the joint property of the marriage on divorce.[23] Women are also entitled to claim maintenance on divorce, but the courts are entitled to take into account any lobola payments made.[24]

3.2.1.2. The Role of the Recognition of Customary Marriages Act in Reducing Women's Vulnerability to HIV

- The minimum-age and consent requirements for a valid marriage in terms of the RCMA will help to protect girls from being forced into early marriages that may put them at risk of HIV infection.
- The equal legal status granted to women married under the Act will encourage the ability of women to own property in their own name and to enter into contracts which will enhance their economic independence and help them to leave risky relationships which put them at risk of HIV infection.
- The economic independence of women is further enhanced by the fact that customary marriages are in community of property, giving women a right to the common property of the marriage and the right to inherit from the marriage under the rules of intestate succession. Allowing women to claim maintenance on the dissolution of a customary marriage also reduces their economic vulnerability.

Although the RCMA recognises polygamy, it goes some way towards protecting women by giving them the choice to end the polygamous relationship (which could put them at risk of HIV infection) by allowing them to claim their fair share of the common property on divorce.

3.3. Male Primogeniture

There is a link between the prevalence of HIV among women and 'laws that inhibit the full enjoyment of

10. Ibid.
11. Ibid.
12. Ibid.
13. Ibid.
14. Act 120 of 1998.
15. S 7(6) and (7).
16. S 3(1).
17. S 2.
18. S 6.
19. S 7(2).
20. Act 70 of 1979.
21. Act 24 of 1987.
22. S 8(1)–(3) of the RCMA.
23. S 8(4).
24. Ibid.

women's rights to land ownership and inheritance'.[25] In the pre-apartheid era, for example, section 23 of the Black Administration Act[26] established the rule of male primogeniture[27] in inheritance among black South Africans, a move which was detrimental to women and girls. With the advent of the HIV pandemic, the detrimental effect of primogeniture became more marked, particularly for women and girls infected with HIV. Under this law, women were robbed of their marital assets at the passing of their husband by his relatives who left them destitute and more vulnerable to HIV.

In *Bhe and others v Magistrate, Khayelitsha, and others (Commission for Gender Equality as amicus curiae); Shibi v Sithole and others; South Africa Human Rights Commission and another v President of the Republic of South Africa and another*[28] the Constitutional Court held section 23 of the Black Administration Act and the regulations enacted in terms of that Act, together with the rule of male primogeniture in South African customary law of succession, to be unconstitutional. The effect of the Bhe case is that all intestate estates which are subject to South African customary law must be transferred to heirs or beneficiaries in terms of the Intestate Succession Act[29] under which the estate of a deceased will benefit a spouse regardless of the surviving spouse's gender and legitimacy of the decedent's children.[30] Subsequently, the Reform of Customary Law of Succession and Regulation of Related Matters Act[31] was enacted to give effect to the judgment in the Bhe case. A person living under customary law may still exercise the right to determine in his will that his estate must be distributed in terms of the applicable customary law of succession and in this way reinstate the rule of primogeniture.

3.4. Child Marriages

Child marriage severely increases young girls' vulnerability to HIV as they are most likely to be forced into having sexual intercourse with their (usually much older) husbands. Young girls have softer vaginal membranes which are more prone to tear[ing], especially on coercion, making them susceptible to HIV and other STIs. Older husbands are more likely to be sexually experienced and HIV infected. The dramatic rise in young married girls' exposure to unprotected sex is driven by pressure to bear children and their inability to negotiate safe sex. The significant age gap in spouses also further intensifies the power differential between husband and wife, which in turn discourages the open communication required to ensure uptake of voluntary counselling and testing for HIV, sharing test results and planning for safe sexual relations throughout the marriage.'[32]

Child marriage also has a negative effect on the socio-economic development of girls. It 'results in their social isolation which is increasingly identified as a predisposing factor for HIV risk because it curtails the social contacts and networks that play a vital role in transmitting HIV prevention information and supporting behavior change'.[33] In addition, '[g]irls who are married at an early age also have low educational attainment and limited or no schooling options, limited control over resources, and little or no power in their new households'.[34]

25. UN Commission on Human Rights 'Women's equal ownership, access to and control over land and the equal rights to own property and to adequate housing', Resolution 2005/25, UN Doc. E/CN.4/2005/RES/25, 15 April 2005, quoted in S Chu and A Symington *Respect, Protect and Fulfill: Legislating for Women's Rights in the Context of HIV/AIDS* Vol. 2: Family and Property Issues, Module 3: Property in Marriage (Toronto: Canadian HIV/AIDS Legal Network, 2009) at p. 3-3.
26. Act 38 of 1927.
27. According to this rule black African women and minor children could not inherit from their male relatives.
28. 2005 (1) SA 580 (CC).
29. Act 81 of 1987.
30. AIDS and Human Rights Research Unit *Human Rights Protected? Nine Southern African Country Reports on HIV, AIDS and the Law* (Pretoria: Pretoria University Law Press, 2007) at p. 264.
31. Act 11 of 2009.
32. International Council of AIDS Service Organisations (ICASO) 'Gender, sexuality, rights and HIV: An overview for community sector organizations' (2007), http://www.icaso.org/publications/genderreport_web_080331.pdf last (accessed December 2014), at p. 10.
33. Ibid. referring to J Bruce and S Clark 'The implications of early marriage for HIV/AIDS policy' (2004), http://www.popcouncil.org/uploads/pdfs/EMBfinalENG.pdf, at p. 3.
34. ICASO (fn. 69 above) at p. 10, referring to J Bruce 'Child marriage in the context of the HIV epidemic' (2007) accessed from http://www.popcouncil.org/uploads/pdfs/TABriefs/PGY_Brief11_ChildMarriageHIV.pdf.

3.5. Female Genital Mutilation and Virginity Testing

Female genital mutilation (FGM) also referred to as female circumcision, female cutting or cutting involves the incision and removal of parts of the most sensitive female external genitalia.[35] The reasons given for this practice vary from community to community.[36] FGM increases the risk of HIV infection in a number of ways.

> 'Firstly, the use of unsterilized razors or knives to carry out the procedure among a number of girls risks passing the virus from one girl to the next should one of them be HIV-positive. Secondly, FGM renders the genitals more likely to tear during intercourse. In cases of infibulation or sewing up of the vaginal entrance, penetration is bound to lead to bleeding, which in turn makes sexual transmission of the virus from an HIV-positive partner much more likely. Thirdly, difficulties with intercourse may make a woman less likely to welcome the partner's advances and lead him to a more violent approach to sex; or to engage in sexual practices with his wife (such as unprotected anal intercourse) which might place her at increased risk of HIV infection.'[37]

The continuation of the practice of FGM amounts to gender-based violence and is thus a form of gender discrimination and a violation of women's right to health, dignity and equality. Although FGM is not widely practised in South Africa, it is practiced by members of the Venda tribe in the north-east of the country.[38] It is generally seen as not being originally a South African custom—but rather one that was 'imported' by immigrants from other African countries, it is specifically prohibited in Section 12(30) of the Children's Act.[39] It is important to flag that the growing migrant populations from countries in which FGM is practised points to possible concerns in future.[40]

Virginity testing involves the physical examination of a girl's genitalia, usually by older women in the community, in order to determine whether the hymen is still intact. Girls whose hymens are found broken will have failed the test, and those whose hymens are still intact will be considered to be virgins. The girls are usually forced to go for virginity testing by their elders.

See sub-chapter 4.2 for a discussion of virginity testing and the rights of children under the Children's Act.

3.6. *Ukuthwala*

Ukuthwala' refers to the practice of marriage by abduction. It involves the forceful abduction of a girl and taking her to a man's home to a life of a forced marriage. The practice is marked by violence, assault, human trafficking and rape. The abduction is usually done by a group of people, one of whom is the future husband. This practice has been linked as a cause of domestic violence, premature and undesired pregnancies, and exposure to sexually transmitted infections and HIV. The *Ukuthwala* practice is quite common in South Africa, particularly in poor rural communities. Although there are a number of cases before the 1994 democratic dispensation that promoted the culture of *Ukuthwala*,[41] as a basis for the formation of a valid customary marriage. This custom lost favour in the case of *Jezile v S and Others*.[42] In this case a 28 year old man, the defendant, arranged a customary marriage with the complainant's uncle which led to her abduction. The complainant was 14 years old at the time. She was restrained and transported to the defendants home. She attempted to escape two times, and was successful the second time in arriving back to her village, but was subsequently apprehended by her uncle and returned to the defendant. During the abduction, she was beaten and raped eight times. After a few days, the complainant managed to escape and sought help from the police. The Wynberg Magistrate's

35. JC Mabangizi 'An assessment of the constitutional, legislative and judicial measures against harmful cultural practices that violate sexual and reproductive rights of women in South Africa. Journal of International Women's studies, Vol 16 (1) at 160.
36. Ibid.
37. Amnesty International 'Women, HIV/AIDS and human rights', ACT 77/084/2004, accessed from https://www.amnesty.org/en/documents/ACT77/084/2004/en, at p. 7.
38. B Kitui 'Female Genital Mutilation in South Africa' https://africlaw.com/2012/06/07/female-genital-mutilation-in-south-africa/ (accessed 9 October 2020).
39. Act 38 of 2005.
40. B Kitui 'Female genital mutilation in South Africa' (2012), http://africlaw.com/2012/06/07/female-genital-mutilation-in-south-africa.
41. *Feni v Mgadlwa* Transkei High Court Case No 24/2002 unreported.
42. (A 127/2014) [2015] ZAWCHC 31; 2015 (2) SACR 452 (WCC); 2016 (2) SA 62 (WCC); [2015] 3 All SA 201 (WCC).

court in the Western Cape Province found the man guilty of *Ukuthwala* and sentenced him to 20 years in prison. The decision of the Magistrate Court was confirmed by the High Court on Appeal.

3.7. Traditional Male Circumcision

The cultural practice of circumcisions undertaken in non-clinical settings can have significant risks of serious adverse events, including death. This practice is seen as the rite of passage into manhood in some cultures and those that do not go for circumcision are never regarded as being men that are worthy of marriage and respect. Some are forced to go to initiation schools by their elders against their will. Often traditional male circumcision is performed in unhygienic environments with unsterilized equipment. This has led to infection, severe loss of blood, mutilation, and even deaths.

See detailed discussion in Sub -chapter 4.2.

4. Legal Remedies under Customary Law

The constitutional obligation of courts with regard to customary law is found in section 211(3) of the Constitution, which provides that the courts 'must apply customary law when that law is applicable, subject to the Constitution and any legislation that specifically deals with customary law.' Customary law is therefore subject to the Bill of Rights and the constitutional human rights.[43] It is within the discretion of the courts to determine whether customary law is applicable in a particular case.

In order to prove the existence of a binding custom or usage (customary law), the court must ensure:

- that particular custom or usage that is being relied on, is still in existence;
- whether the custom or usage is legally binding on the community or whether it is merely optional.

Customs or usages are usually proven by means of expert evidence. In *Sigcau v Sigcau*, the court held that the only way in which the court can determine a disputed point which has to be decided according to "native custom" is to hear evidence regarding that custom from those best qualified to give it (for example, elders and sages) and to decide the dispute in accordance with such evidence as it appears in the circumstances to be most probably correct.

4.1. The Traditional Courts Structure

The traditional justice system 'affirms the values of customary law and is deeply rooted in the principles of restorative justice and reconciliation'.[44] As a results, traditional courts have remained an important aspect of people's lives, especially those who live in communities that are led by chiefs, headsman and kings. Thus, the traditional court system forms an important part of the administration of justice in South Africa and can be utilised to protect the rights of people who live in those communities.[45]

The administration of justice in the formal traditional courts is 'multi-layered, complex and flexible' as it is applied differently depending on a particular situation at a particular community.[46] The flexibility allows for the procedure observed in hearing of matters in the traditional courts to be inconsistent with the laws and customs of the traditional community in question.[47] However, what is common in traditional structures is the traditional value of Ubuntu. In the case of *S v Makwanyane and Another*,[48] the concept of Ubuntu was described as a value that '[T]ranslates as humaneness. In its most fundamental sense, it translates as personhood and morality. Metaphorically, it expresses itself in *umuntu ngumuntu ngabantu*, describing the significance of group solidarity on survival issues so central to the survival of communities. While it envelops the key values of group solidarity, compassion, respect, human dignity, conformity to norms and collective unity, in its fundamental sense it denotes humanity and morality. Its spirit emphasises respect for human dignity, marking a shift from confrontation to conciliation.

43. M Mswela 'Cultural practices and HIV in South Africa: A legal Perspective' PER Vol 12 (4) 2009 at page 179/360.

44. CB Soyapi 'Regulating traditional justice in South Africa: A comparative analysis of selected aspects of the Traditional Courts Bill'. PER Vol 17 (4) 2017 at 1442.

45. Ibid

46. Christa Rautenbach ' Legal Reform of Traditional Courts in South Africa: Exploring the Links Between Ubuntu, Restorative Justice and Therapeutic Jurisprudence' African Journal of International and Comparative Law. December 2015 2(2) at 278.

47. Ibid.

48. 1995 (6) BCLR 665.

The Traditional Courts Bill 2017 ('the Bill') was introduced in the National Assembly in 2008. The Bill attracted criticism from various civil society groups, academics and parliamentarians as lacking. The criticism was that the legislature has ignored 'fundamental issues that are central to traditional justice such as ascertainment, legal representation, jurisdiction, gender and the hierarchy of courts.'[49]

Although not passed into law yet, some positive aspects of the Bill may assist in guiding legal practitioners to advise members of communities on how to engage with traditional authorities in communities where these structures still exist:

4.1.1. The Guiding Principles of the Bill

- The need to align traditional courts with the Constitution regarding the right to human dignity, the achievement of equality and the advancement of human rights and freedoms, the promotion of non-racialism, non-sexism and the freedom of sexual orientation and identity, and religion; and
- The promotion of restorative justice measures through mediation and conciliation.

4.1.2. The List of Customs and Practice

The Bill contains an 'indicative, non-exhaustive list of customs and practices which infringe on the dignity, equality and freedom of persons and which are prohibited: LGBTI discrimination, homophobia, discrimination against persons who are mentally or physically disabled, and discrimination against persons with albinism and unmarried persons.'[50]

4.1.3. Restorative Justice

The concept of restorative justice is defined in the Bill as an 'approach to the resolution of disputes that involves all parties to a dispute, the families concerned and community members in order to collectively identify and address harms, needs and obligations by accepting responsibility, not only in order to effect restitution, but also to take measures to prevent a recurrence and to promote reconciliation'.[51]

4.1.4. Applicability

Any person may institute proceedings in respect of a dispute in any traditional court. However, the nature of disputes which a traditional court may hear are limited to the following:[52]

- Theft, malicious damage to property, burglary and receiving stolen property, all of which are subject to the value in question not exceeding R15 000
- *Crimen injuria* (ie, the unlawful impairment of another's dignity);
- Advice relating to *ukuthwala* initiation, customary law marriages, custody/guardianship of minor children, succession and inheritance and customary law benefits;
- Customary law matters where the matter in dispute does not exceed an amount determined by the Minister from time to time by notice; and
- Altercations between members of the community.

Disputes that are being investigated by the South African Police Services or those that are pending before another traditional court or any other court or which have been finalised by a court are excluded.

4.1.5. Hierarchy of Courts

No specific hierarchy of courts in the traditional court structure and no forma 'opt out' clause exists if a person does not want to submit to the jurisdiction of the court. The Bill only allows possible transfer of matters to the Magistrate's Court. The transfer is not mandatory, it is left to the justice of the peace, after being alerted by the clerk of the traditional court to the failure of a party to attend court, to 'request' the traditional court to have the matter transferred to a Magistrate's Court.

4.1.6. Presiding Officer

The Bill provides for various traditional leadership that makes up the traditional court system and as contemplated in the Traditional Leadership and Governance Framework Act.[53] A traditional court must be presided over by a traditional leader or any person designated by the traditional leader.

49. Op cit note 43 at 1442 – 1443.

50. Anton van Dalsen 'The Traditional Courts Bill: A problematic piece of legislation'09 April 2019 accessed from https://www.politicsweb.co.za/opinion/the-traditional-courts-bill--a-problematic-piece-o –| 13 November 2020.

51. Ibid.

52. Ibid.

53. Act 41 of 2003 (as amended).

4.1.7. Proceedings

- Traditional courts must function in accordance with customary law, but subject to the Constitution.
- Proceedings require full and equal participation by women and that vulnerable persons are treated in an appropriate manner
- Traditional courts must give a fair hearing to persons who may be affected by its decision and that any decision must be impartial.
- A party to a dispute may be assisted by a person of his or her choice, but no one may be represented by a legal practitioner.
- Hearings must be open to all members of the community.

4.1.8. Orders

The traditional court is empowered to make the following orders:

- An order in monetary terms or otherwise, including livestock, provided that any such order may not exceed the value of the damage giving rise to the dispute;
- A non-monetary order of the rendering of a service, subject to the consent of both parties, if the party against whom proceedings were instituted cannot comply with a financial order;
- Some form of community service, provided that no service may be rendered in this regard to a traditional leader or family;
- An order directing that the matter be submitted to the National Prosecuting Authority for the possible institution of criminal proceedings; and
- Accept an unconditional apology as part of a settlement between parties or it may simply issue a reprimand.

4.1.9. Non-compliance with Orders and Appeals

If an order of a traditional court is not complied with, the clerk of the court must refer the matter to a justice of the peace, who is empowered to summons the defaulting party to a traditional court for purposes of having the matter transferred to a Magistrate's Court, 'to be dealt with afresh'.

The Bill uses the concept of 'referral' and not that of 'appeal'.

A party to the proceedings may take the matter on review to the High Court, but such a review is limited to procedural aspects, and may not concern the merits of the case.

If the review concerns the merits, the aggrieved party may, after exhausting all traditional court system appeal procedures, 'refer' the matter to a Magistrate's Court, which is entitled to hear evidence and to make an appropriate ruling.

Concluding Remarks

In December 2020, the Global Fund Executive Director, Peter Sands, stated that: *'World AIDS Day reminds us that while we battle to contain COVID-19, we still haven't finished the fight against the last big pandemic to hit humanity. After four decades and the loss of over 32 million lives, the battle against HIV is still unwon. In 2019, 690,000 people died from Aids-related illnesses while an estimated 1.7 million additional people were infected with HIV – the same number as in 2018. And while more than 26 million people are on treatment, more than 12 million are still waiting for it. In some areas, progress has stalled or is reversing.''*[1]

Here in South Africa, we are also reminded that we cannot win the battle against HIV if we do not fight TB. Further, the South African efforts to combat HIV and TB epidemics must always be accompanied by an unwavering commitment to respect the rights enshrined in the Constitution. We need to continue to educate and empower all South Africans to fight stigma and discrimination against people living with and affected by HIV (PLHIV) and those that have TB.

South Africa has over the years developed a progressive legal and policy framework to protect the rights of key and vulnerable population. The legal and policy framework should be used to ensure that this population is educated and empowered to assert its right to equality, dignity and privacy, especially in the context of access to health care. The production of the *'Reducing Human Rights Related Barriers to HIV & TB Services for Key and Vulnerable Populations: Legal Support Resource'* is a recognition that PLHIV and those that have TB continue to face a wide range of discriminatory practices in many settings. They are subjected to, inter alia, stigma, unfair dismissal in the workplace, domestic violence after they disclose their HIV status, and limited access to HIV treatment, with care and support often being denied.

We hope that this Legal Support Resource will serve as a useful tool on HIV, TB, human rights and law for paralegal and legal practitioners. In addition, it can be used as a reference and guide to people who work in the field of health and human rights. We also hope that it will create greater awareness and renewed commitment amongst lawyers, advocates and activists to engage in law-driven social transformation work on behalf of PLHIV and those with TB in under-resourced communities in South Africa.

With this Resource, let us help promote human rights and access to justice!

1 See Peter Sands ' How the lessons the world learned in fight against HIV can help us defeat COVID-19' 02 December 2020 accessed at https://www.theglobalfund.org/en/blog/2020-12-02-how-the-lessons-the-world-learned-in-the-fight-against-hiv-can-help-us-defeat-covid/

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